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**PROPOSED LEGISLATION TO ALTER MEDICARE/
FEDERAL EMPLOYEE HEALTH BENEFIT PLAN COVERAGE**

HEARING
BEFORE THE
SUBCOMMITTEE ON CIVIL SERVICE, POST
OFFICE, AND GENERAL SERVICES
OF THE
COMMITTEE ON
GOVERNMENTAL AFFAIRS
UNITED STATES SENATE
NINETY-SEVENTH CONGRESS
FIRST SESSION

JUNE 2, 1981

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PROPOSED LEGISLATION TO ALTER MEDICARE/ FEDERAL EMPLOYEE HEALTH BENEFIT PLAN COVERAGE

TUESDAY, JUNE 2, 1981

U.S. SENATE,
SUBCOMMITTEE ON CIVIL SERVICE,
POST OFFICE, AND GENERAL SERVICES,
COMMITTEE ON GOVERNMENTAL AFFAIRS,
Washington, D.C.

The subcommittee met at 10:30 a.m., in room 3302, Dirksen Senate Office Building, Hon. David Pryor presiding.

Present: Senator Pryor.

Staff present: Wayne Schley, staff director; Jamie Cowen, chief counsel; Pat Halcomb, chief clerk; Knox Walkup, minority staff director; Margaret Sims, Senator Mathias' staff; and Louis Light, minority staff assistant.

Senator PRYOR. Ladies and gentlemen, the committee will come to order at this time.

Senator Stevens cannot be present with us. He is, I understand, at the White House, so that preempts just about any other appearance. We would certainly understand that.

In his absence, I will insert his opening statement in the record at this point.

[The prepared statement of Senator Stevens follows:]

OPENING STATEMENT OF SENATOR TED STEVENS

The purpose of today's hearing is to receive testimony on a measure ordered to be reported by the Finance Committee which requires the insurers under the Federal Employees Health Benefits Program to be the primary payor for both active and retired federal employees over age 64 who are also covered by Medicare. This proposal reverses the current policy where Medicare is the primary payor and the federal employee health carriers are the secondary ones.

As I understand it, this measure shifts \$1 billion in actual outlays from Medicare to the federal health program. Actual budget savings, however, approximate \$400 million due to the Government/employee contribution ratio of 60/40.

This proposal raises some serious issues such as the cost implications for federal employees, the equity involved in singling out one segment of our society to assume this burden and administrative complexities which this measure will create. We must remember that federal employees are not eligible for Medicare unless they qualify for social security benefits. In other words, they are not covered by Medicare by virtue of federal employment. In contrast, many other groups such as state and local government employees and private sector workers who are covered by private insurance will still retain Medicare as their primary payor under this proposal.

In addition, I understand that in some cases premiums for certain health plans will double, causing dramatic shifts from one plan to another. Those most hurt will clearly be the elderly who need the coverage the most and who are the least able to pay for drastically increased premiums.

Federal employees and retirees have already assumed their share of budget cuts. If the rumors regarding the impact of this proposal are true, I hope we can take a second look at this before approving it.

OPENING STATEMENT OF SENATOR PRYOR

Senator PRYOR. I would like to take just a moment to commend Senator Stevens, the chairman of this subcommittee, for initiating the hearing this morning. It concerns the very important issues affecting the Federal Employees Health Benefits Program. At a time when health care costs are substantial and major questions exist about other Federal employee benefits, such as retirement, I think it is most critical that the Congress at this time have as much information as possible about any proposed changes in the health benefits program.

Legislative changes proposed by the Senate Finance Committee and the House Ways and Means Committee could well change Medicare to a supplemental health care system for Federal employees and make the Federal employees plans the primary system. Such changes would increase the cost of the Federal employees plans and increase—in some cases substantially increase—the cost of premiums to those participating in those plans.

Today we are searching for answers. We need to find answers to some very critical questions about these proposals, such as:

One, what are the budgetary effects of this proposal, and will there be new costs which have not been considered?

Two, what effect will the proposals have on premium costs of employees and retirees?

Three, what effect will changes have on OPM's administration of the program?

Four, what effect will the changes have on the plans themselves in terms of enrollment changes, administrative burdens, and cost assumptions?

Finally, what effect will one or more changes in benefits have on employee and retiree morale and the future role of the Federal Government as an employer?

I think that the Federal employees and retirees deserve our answer, and it is for this reason that Senator Stevens has called this committee meeting.

We have as our first witness Dr. Donald J. Devine, Director of the Office of Personnel Management. He is accompanied by Mr. Gary Nelson, who is the Associate Director for Compensation, Office of Personnel Management.

I would at this time allow you to submit your statement or summarize your statement, Dr. Devine, and Mr. Nelson. We look forward to hearing from you.

TESTIMONY OF DONALD J. DEVINE, DIRECTOR, OFFICE OF PERSONNEL MANAGEMENT, ACCOMPANIED BY GARY NELSON, ASSOCIATE DIRECTOR FOR COMPENSATION, OFFICE OF PERSONNEL MANAGEMENT

Mr. DEVINE. Thank you very much, Senator. I would like to summarize some of the high points and have my full statement entered into the record.

I appreciate the opportunity to talk about this subject of great interest to Federal employees.

The Senate Finance Committee is considering, as a part of the budget reconciliation process, a proposal to reverse the existing primary and secondary payor roles of Medicare and the Federal Employees Health Benefits Program. This reversal of primary and secondary payor roles would not be expected to reduce the total health care benefits available to the affected individuals, but it could shift an estimated \$960 million in annual costs from Medicare to the Federal Employees Health Benefits Program. Since the costs of FEHB are shared by the Government and the enrollees in the program, the net effect of this shift is estimated to be an outlay reduction of \$390 million. The House Ways and Means Committee is considering a somewhat more modest proposal.

While we have reservations as to whether the actual savings would be of the magnitude suggested, the amount of savings would be substantial, and this is obviously very attractive at a time when the administration and the Congress are working together to reduce Government expenditures.

Making FEHB rather than Medicare the primary payor would increase FEHB premiums by about 20 percent on the average for the Senate proposal and about 4 percent for the House proposal, on top of premium increases due to rising health care costs.

This sharp increase in premiums, and its uneven distribution, could lead to two results. First, many of the individuals with Medicare eligibility might drop out of FEHB altogether, so they could once again receive their health care benefits from Medicare. Second, we can foresee that employees and annuitants in the FEHB program may start changing plans, trying to escape the high premiums in the plans where the remaining Medicare eligibles are enrolled.

We are already reaching a point in our normal FEHB cycle where we must negotiate the rates for the 1982 contract year, and the added uncertainties presented by the proposed changes would make it difficult for us to complete the negotiation process in time for the annual open season this November.

Although we see some serious problems in these particular proposals, we think it must be recognized that there are also problems in the existing relationship between Medicare and FEHB. It may be necessary to make some changes in that relationship.

Yet, this is a very complicated subject, and we haven't had time to analyze it thoroughly. We do not know the real extent of the windfall problem in the present Medicare/FEHB relationship, and we don't know what alternatives there may be to a simple reversal of the existing primary and secondary payor roles. Therefore, we believe it is premature to support such changes at this time.

The possible consequences can be serious, so we think that this proposal should undergo thorough analysis by this committee and the appropriate committee on the House side. Therefore, we believe that it is premature to support the proposal at this time.

That ends my formal statement. I would be happy to answer any questions.

Senator PRYOR. Mr. Nelson, do you have a statement at this time?

Mr. NELSON. No, Senator.

Senator PRYOR. Let me then start off with a few questions that would be propounded this morning by Senator Stevens if he were here. As I understand it, he is on his way here, if I am not mistaken.

First, does the administration support or oppose the action taken by the Senate Finance Committee?

Mr. DEVINE. As I mentioned, we do not support the action taken by the Senate Finance Committee.

Senator PRYOR. Have you expressed your opposition, say, in the right circles or to the right people within the administration?

Mr. DEVINE. Yes. They are aware of this. The Office of Management and Budget has cleared my statement, which indicates that we do not support the Senate Finance Committee proposal at this time. The bill requires further consideration and alterations before we are going to be able to support anything like it.

As I mentioned in my statement, we do recognize that there may be some windfall effects and that some kind of change in the relationship might have to take place. But we don't believe that we can support the Senate Finance Committee actions.

Senator PRYOR. Would you carefully review how and where costs might be shifted under the Finance Committee proposal?

Mr. NELSON. Senator Pryor, the Senate Finance Committee proposal would take \$960 million, which is the estimated Medicare payments to people also eligible to be enrolled in the Federal Employees Health Benefits Program, and shift those costs to the FEHB. The shift would not be across-the-board because in fact the annuitants tend to be concentrated in relatively few of the large plans. Therefore, in terms of what the enrollee would pay, we would see a very different distribution of costs, with increases in some cases well over 100 percent, even well over 300 percent. In other cases there would be only very slight changes. That would cause equity problems and also instability, because we would expect to see people looking at increases in premiums and making decisions to change plans.

Senator STEVENS [presiding]. Let me interrupt just 1 minute. I want to apologize to my good friend, Senator Pryor, for being late, and to you gentlemen.

I have just come from a meeting with the President. Now I have been called to the Conference on Supplemental Appropriations to our section of the defense appropriations bill.

I want to ask—I understand that you will be able to continue the hearings for a while yet today.

Senator PRYOR. I need to be gone from here around 11, if I could.

Senator STEVENS. When you recess, could we reschedule this for tomorrow at 10 a.m.? I will do my best to get back with it. We should be finished with my portion of the Supplemental today, and I can be back tomorrow. Thank you very much, and my apologies.

Senator PRYOR [presiding]. I would like to say, Dr. Devine, this is one of the privileges of being in the minority these days. You don't have quite as much to do and are not quite as busy as last year. [Laughter.]

Have we been able to ascertain what effect these changes as proposed by the Finance Committee might have on the individual Federal retiree? You referred to some windfall a while ago, but really there is a windfall on the other side that many retirees are worried about. That is that they are going to have fewer benefits from their program that they are enrolled in. I wonder if you would discuss that for a moment.

Mr. NELSON. Senator, my understanding of the way the Finance Committee proposal would work is that the retirees would still get the same benefits but that retirees and other enrollees in the FEHB program would pay much higher premiums as a result. The cost would be paid not only by retirees, but it would also be paid by active employees.

Senator PRYOR. Is this an implied contract that the Government has with the employees? Are we changing the program in midstream, so to speak, or is this something that they have been given notice of some time in advance?

Mr. NELSON. Senator, I think a change of the magnitude suggested by the Senate Finance Committee would be a very sudden change, with very little advance warning, and would cause major problems in the stability of the program, as Dr. Devine's statement mentioned.

One of our problems, of course, with it is that this is such a new proposal, we really haven't had time to completely evaluate it.

Senator PRYOR. Would the Federal employee program, as proposed by the Senate Finance Committee, increase administrative costs; for example, costs to OPM and administrative costs for plans that we are speaking of?

Mr. DEVINE. I think it is pretty clear that it would increase administrative costs. It would make it difficult for us to make any of the necessary changes in rates in the time available.

We had some very preliminary talks with HHS. I think the important thing to stress is the suddenness of this. Its early effective date would create significant administrative problems.

Senator PRYOR. Does the proposal as proposed by the Senate Finance Committee mean that earned Medicare benefits might be lost, that a non-Federal employee whose spouse earns social security benefits would be under Medicare's primary coverage while a Federal employee would not? Is this a proper allegation, or is there any truth in this allegation?

Mr. NELSON. That is correct, Senator Pryor. Medicare would be secondary for the Federal retiree who is eligible for both programs, which means it would pay only after the Federal Employees Health Benefits Program paid. Therefore, there would be less paid by Medicare.

Senator PRYOR. What effect, then, will this have on the open season for plan enrollment? I think Dr. Devine alluded to the open season coming up before too much longer. What effect is this going to have?

Mr. DEVINE. Well, with the tremendous changes in premiums which would take place, assuming people act rationally, I expect participants would try to get out of programs in which the increases are greatest. We would certainly have to consider the possibility of not having an open season. I am not saying we wouldn't have an open season, but we would have to consider cancellation of it because of the tremendous disruption that could take place.

Senator PRYOR. This might actually result in reducing benefits to the Federal employees. Is that correct?

Mr. DEVINE. The benefit of being able to shift from one program to another? Yes, if we went that way.

Senator PRYOR. In addition to causing that employee to pay more into the program than prior circumstances dictated?

Mr. DEVINE. Yes, Senator.

Senator PRYOR. What about Federal employees as taxpayers paying in part for their Medicare and getting their coverage by virtue of their work or their spouse's work? Aren't they also being singled out here for some discriminatory treatment?

Mr. DEVINE. Some questions have been raised as to the constitutionality of singling out one class of individuals to have Medicare the first payor rather than the second. We don't have a formal opinion on its constitutionality, but the question has been raised and I think it has some merit.

Mr. NELSON. It is particularly relevant, Senator—there are two parts of Medicare. Part A is funded by the trust funds, based on contributions by employees and employers. Part B is funded by enrollment charges to people who belong to the program, plus a subsidy from the general tax revenues of the United States. Part B is open to everyone.

Senator PRYOR. What would be your reaction to a congressionally mandated review of FEHB and Medicare coverage with a directive to supply recommendations by December 31 or some other date?

Mr. DEVINE. As I mentioned in the testimony, we think that there may be some windfall effects to Federal employees in this arrangement, and we are willing to review them ourselves. We would certainly be willing to do so under a congressional mandate.

Senator PRYOR. I am going to ask two or three questions for Senator Stevens, in his behalf, at this time. Then we will conclude our hearing, going back into session tomorrow at 10 a.m., I believe.

Is there a possibility that certain health carriers would go bankrupt under such a proposal, as proposed by the Senate Finance Committee?

Mr. DEVINE. If a plan's premiums are set too low, it might be forced into bankruptcy and have to terminate FEHB participation. Under OPM regulations, if an FEHB plan is discontinued, each employee and annuitant whose enrollment is thereby terminated may enroll in another FEHB plan. But the new plan would not be responsible for reimbursement of health services rendered under the previous enrollment, and in some cases enrollees would be held personally liable for outstanding claims from health care providers.

Senator PRYOR. So it would look somewhat bleak for the Federal employees enrolled in those particular programs if the premiums were not sufficient to carry them. Is that correct?

Mr. DEVINE. Yes, Senator.

Senator PRYOR. What are the cost savings attributable to this proposal?

Mr. DEVINE. It has been estimated by the Senate Finance Committee to save \$390 million.

Mr. NELSON. Senator, there is some uncertainty in the cost estimates. The \$390 million figure that we have seen would assume an October 1 commencement date for this. We understand the Senate Finance Committee proposes that it really start on January 1. If that is the case, then the savings would be more on the order of \$270 million in outlays for the Government for 1982. Of course, the costs transferred from Medicare to the FEHB program would be considerably larger. There is a savings in outlays only because employees and annuitants pay 40 percent of the cost of the program.

Senator PRYOR. We have talked about an increase in administrative costs, but have we put a dollar figure on that increase?

Mr. DEVINE. We can't estimate it at this time.

Senator PRYOR. Would it be substantial?

Mr. DEVINE. I would suspect it would be substantial.

Senator PRYOR. So if we save \$390 million under the Senate Finance Committee proposal, that is going to be offset by an increase in administrative costs?

Mr. DEVINE. Well, certainly not of that magnitude, but it would be substantial.

Mr. NELSON. Not of that magnitude, Senator. But one of the problems that would occur is if there are delays, there may be administrative problems with the January 1 effective date.

Senator PRYOR. In your view, will most employees over 65 fully understand the changes with Medicare and therefore make correct decisions on what is best for them?

Mr. DEVINE. I think that is a significant problem. Although we have a very well educated group among Federal retirees, I still think that there would be a problem.

There are offsetting possibilities here. The more rationally people act in their own interests, the better it protects them. But it also has more effect on changing the ratio of people in one plan to another.

Senator PRYOR. Let us just have a moment to make sure that we are firm for the hearing tomorrow. Would that be convenient for you two gentlemen to be back on the scene tomorrow?

Mr. DEVINE. I don't think it is for me, but I am sure Mr. Nelson could come.

Mr. NELSON. I would be delighted to appear, Senator.

[The prepared statement of Mr. Devine and responses to written questions from Senator Stevens follow:]

PREPARED STATEMENT OF DONALD J. DEVINE, DIRECTOR, OFFICE OF PERSONNEL
MANAGEMENT

Mr. Chairman and Members of the Subcommittee: I appreciate the opportunity to appear this morning to discuss the relationship between Medicare and the Federal Employees Health Benefits Program. Accompanying me is Gary R. Nelson, our Associate Director for Compensation.

The Senate Finance Committee is considering, as a part of the budget reconciliation program, a proposal to reverse the existing primary and secondary payor roles of Medicare and the Federal Employees Health Benefits—or FEHB—Program. Under current law, an individual who is covered under both programs has most of his medical costs paid for by Medicare, with his FEHB health insurance plan paying benefits only to the extent Medicare has not paid them. Under the Finance Committee proposal, this relationship would be reversed. The FEHB plan would be required to pay benefits to the same extent it would for an enrollee who is not covered by Medicare. Furthermore, Medicare would only pay those amounts not covered by the FEHB plan, subject to its standard maximum payment limit.

This reversal of primary and secondary payor roles would not be expected to reduce the total health care benefits available to the affected individuals, but it could shift an estimated \$960 million in annual costs from Medicare to FEHB. Since the costs of FEHB are shared by the Government and the enrollees in the Program, the net effect of this shift is estimated to be an outlay reduction of \$390 million. The House Ways and Means Committee is considering a somewhat more modest proposal. This proposal would make Medicare Part B secondary for all dual beneficiaries; Medicare Part A would be secondary only for new retirees. This proposal would save \$70 million in fiscal 1982 rising to \$170 million in 1986.

While we have reservations as to whether the actual savings would be of this magnitude, the amount of savings would be substantial, and this is obviously very attractive at a time when the Administration and the Congress are working together to reduce Government expenditures. After reviewing this whole subject, we have reached the conclusion that some change in the current cost sharing between Medicare and FEHB does indeed appear to be warranted. However, the particular proposals at hand present a number of problems which I will discuss. Until the Administration better understands their implications, it would be premature for us to support these initiatives without exploring possible alternatives.

Making FEHB rather than Medicare the primary payor would increase FEHB premiums by about 20 percent on the average for the Senate proposal and 4 percent for the House proposal on top of premium increases due to rising health care costs. Since the Medicare eligibles tend to be enrolled in only a few of the largest FEHB plans, this increase would not be spread evenly across the whole Program, but would instead be concentrated in those few large plans. The increase in premiums in some of the plans due to the Medicare change could be as high as 70 percent.

This sharp increase in premiums, and its uneven distribution, could lead to two results. First, many of the individuals with Medicare eligibility might drop out of FEHB altogether, so they could once again receive their health care benefits from Medicare. This, of course, would shift costs back to Medicare. Although there is uncertainty about the magnitude, this effect is included in the estimates. The second result we would foresee is that employees and annuitants in the FEHB Program may start changing plans, trying to escape the high premiums in the plans where the remaining Medicare eligibles are enrolled. This could exacerbate current problems of adverse selection and exert a destabilizing influence on the Program. It is also unclear to us how deductibles and co-insurance payments would be handled under the proposal, and it is possible that Medicare and FEHB in reversed payor roles might end up paying more in total benefits than they do under the current payor relationship.

Since large numbers of providers and beneficiaries would have to change the forms they fill out and understand that Medicare is now the secondary payor and since Medicare would have to work out a mechanism for coordinating its benefits with 119 FEHB plans with different benefit levels, we would expect considerable initial confusion.

We are already reaching a point in our normal FEHB cycle where we must negotiate the rates for the 1982 contract year, and the added uncertainties presented by the proposed change would make it difficult for us to complete the negotiation process in time for the annual open season this November.

We have been reviewing what administrative actions we could take in order to keep the FEHB Program operating if one of these changes does indeed become law. One option we would have to consider very seriously would be to cancel or delay the open season this year, thus preventing or delaying enrollees from changing plans. This would stave off the destabilizing enrollment changes we would otherwise expect, and give us and the carriers time to determine the actual impact of the shift in payor roles. Of course, it would also force employees and

annuitants to remain in the plan they are now in, despite the drastic premium increases, or drop out of the FEHB Program altogether.

Although we see some serious problems in these particular proposals, we think it must be recognized that there are also problems in the existing relationship between Medicare and FEHB. Like Social Security, Medicare includes within its design certain social welfare elements. These include providing benefits to those whose careers under Social Security were relatively brief, or who did not work under Social Security at all, but may have a spouse who did. However, when an individual is already receiving Federal benefits as a result of a career under a Federal retirement system rather than Social Security, we do not think it is reasonable to also give him the social welfare portion of Social Security benefits. Our concern over these "windfalls" led the Administration to include in its Social Security proposals an offset formula, so that individuals who are receiving a Federal retirement annuity will not also receive the advantage of the social welfare aspects of the Social Security benefit computation formula.

The proposed Medicare change, however, may go beyond the windfall element of the present payor relationship. Instead of an offset designed to eliminate only the windfall, it might not sufficiently take into account individual payment of the Hospital Insurance Tax that partially funds Medicare by those individuals also covered by FEHB.

This is a very complicated subject, and we have not had time to analyze it thoroughly. We do not know the real extent of the windfall problem in the present Medicare/FEHB relationship, and we do not know what alternatives there may be to a simple reversal of the existing primary and secondary payor roles. Accordingly, we believe it would be premature to support such changes at this time.

Thank you very much. I would be pleased to answer any questions you may have.

RESPONSES TO WRITTEN QUESTIONS FROM SENATOR STEVENS

1. Q. I understand that OPM is beginning negotiations with health carriers for the 1982 health plans. How is the proposal going to affect the negotiations?

A. OPM is currently in the process of negotiating new contracts for 1982 and decisions on benefits and premium charges must be made before July 31st. Although the Medicare issue has not been formally discussed, we would expect that passage of the Senate Finance Committee proposal would throw the negotiation process and the entire FEHB program into turmoil, causing very serious disruptions for enrollees, carriers, and OPM.

I should also mention once again that a very real possibility which we may be faced with is the prospect of having to cancel open season this year in order to maintain some stability in the FEHB program.

2. Q. What will be the impact on premiums of such a proposal? Do you have any examples?

A. It is estimated by our Actuary that the Medicare change would increase FEHB premiums by about 20 percent on the average--on top of premium increases due to rising health care costs, which are expected to be about 15 percent. This increase would not, however, be evenly spread across the whole program. Instead, it would be concentrated in those few large plans which have most of the Medicare-eligibles. These few large plans would experience premium increases as great as 100 percent. For example, it is estimated that Aetna low-option, self-only, would rise 165 percent; Blue Cross low-option, self-only, 95 percent; Aetna high-option, self-only, 50 percent; Blue Cross low-option, family, 40 percent, and so on. A chart which shows possible FEHB premium increases due to the Medicare change as well as inflation is attached.

3. Q. In what plans are there high Federal retiree concentrations?

A. The largest number of annuitants tend to be concentrated in the few larger FEHB plans. Annuitants make up 576,011 or 40 percent of Blue Cross high-option enrollees; 172,269 or 48 percent of Aetna high option enrollees; 139,408 or 45 percent of Blue Cross low-option enrollees; and 67,221 or 57 percent of Aetna low-option enrollees. Attached is a breakdown for some of the other plans.

4. Q. Do you expect large shifts from one plan to another?

A. We have no way of predicting actual numbers of enrollees who may change plans. Traditionally, the FEHB program has experienced shifts of approximately 5 to 7 percent during open season. Common sense, however, tells us that we should expect much larger shifts due to the extremely high premium increases we expect would be experienced by the plans with the most annuitants.

5. Q. Can the rates for health plans be varied during the year to compensate for unpredictable transfers due to the proposal?
 - A. While we have never done so, we would be able to change the rates during the contract year by mutual agreement with each carrier. This would present very great administrative problems, however, and would lead employees to call for a new open season.
6. Q. Who will assume the burden of various administrative tasks?
 - A. It is unknown exactly what burdens would be assumed by each of the parties, since we have not yet had the opportunity to discuss with HHS how we would administer the proposal. We have not discussed the issue in great detail with the carriers either at this point.
7. Q. Does this proposal violate the intent of the Paperwork Reduction Act of 1980?
 - A. We have not at this time explored the impact this change would have on paperwork, but we would expect the impact, if any, to be kept to a minimum.
8. Q. Could a carrier devise a plan that only covers what Medicare would not pay today, so that Medicare continued to cover the same things?
 - A. It is possible that a carrier could devise new plans within OPM guidelines that would cover only what Medicare does not cover. We are now in the process of exploring such options and their feasibility internally at OPM.

Plan Premium Increases Due to Medicare and Inflation
(Estimates for 1982)

High Option

Self	Total Bi-weekly Premium '81	Medicare %	Inflation %	1982 Total	Employee Share 1981	1982
BC	30.05	x 1.25	x 1.15	43.19	14.84	20.88
Aetna	25.38	x 1.50	- 38.07	43.78	10.17	21.47
NALC	26.27	x 1.34	- 35.20	40.48	11.06	18.17
APMU	25.27	x 1.28	- 32.35	37.20	10.06	14.89
Kaiser - N.	19.76	x 1.15	- 22.72	26.13	4.55	3.82
Kaiser - S.	25.37	x 1.11	- 28.16	32.38	10.16	10.07
High 6 Average	25.35	x 1.276	- 32.34	37.19		
60% Gov't Contr.	15.21			22.31		
Family						
BC	66.16	x 1.10	- 72.78	83.70	30.52	37.43
Aetna	50.75	x 1.23	- 62.42	71.78	15.11	25.51
NALC	62.87	x 1.10	- 69.16	79.53	27.23	33.26
APMU	61.10	x 1.09	- 66.60	76.59	25.46	30.32
Kaiser - N.	50.35	x 1.16	- 58.41	67.17	14.71	20.90
Kaiser - S.	65.17	x 1.12	- 72.99	83.96	29.53	37.67
High 6 Average	59.40	1.129	67.06	77.12		
60% Gov't Contr.	35.64			46.27		
BC						
Low Self	9.84	x 1.95	- 19.20 x	22.08		
Low Family	28.57	x 1.40	- 40.00	46.00		
Aetna						
Low Self	12.79	x 2.65	- 33.89	38.97		
Low Family	30.24	x 1.56	- 47.17	54.24		

Percentage of Annuitants in FEHB Plans

	<u>Total Enrollees</u>	<u>Annuitants</u>	<u>Percent Annuitants</u>
Blue Cross - High	1,450,027	576,011	.397
Blue Cross - Low	312,277	139,408	.446
Aetna - High	356,086	172,269	.482
Aetna - Low	118,200	67,221	.569
NALC	180,873	55,002	.304
APWU	214,041	57,359	.268
Kaiser - Northern	71,673	20,892	.291
Kaiser - Southern	53,236	12,095	.227
GERA	98,714	13,190	.134
Rural Letter Carrier	39,964	16,786	.420
AFGE	38,330	8,837	.231
Canal Zone	19,344	8,104	.419
NAGE	4,953	124	.025

Senator PRYOR. We are set for 10 a.m. in the morning.

With that in mind, I want to say thank you very much for your testimony. We will be back in session at 10 a.m. tomorrow morning.

[Whereupon, at 10:55 a.m., the subcommittee was recessed, to reconvene at 10 a.m. on Wednesday, June 3, 1981.]

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD



EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

JUN 2 1981

The Honorable Ted Stevens
Chairman
Subcommittee on Civil Service,
Post Office, and General Services
Washington, D. C. 20510

Dear Ted:

Thank you for the opportunity to comment on proposed legislation requiring Federal Employee Health Benefits Plan carriers to assume primary insurer status for those FEHB enrollees eligible for Medicare. The Administration is not opposed, in principle, to changing the current cost-sharing arrangement between Medicare and FEHB. There are a number of serious questions that must be answered, however, before the Administration could support such a move.

First, the magnitude of increases in carrier premium charges and the extent to which employees would shift plans in response to these increases are not known at this time. Were premiums and reserve levels to increase across the board, Federal contribution costs would rise, offsetting in part whatever savings are generated in Medicare by making Medicare a secondary insurer for eligible FEHB enrollees. Because little is known about responses to major premium charge changes in the FEHB market, the actual magnitude of such offsetting costs is difficult to estimate with any precision. The degree of instability and its attendant problems would depend on ultimate coverage (e.g., application to prospective retirees administratively would not be as adverse).

Second, there is some question about the effect of such legislation on contracts now, or soon to be, in force with FEHB carriers. The next open enrollment date for Federal employees and retirees is in November. Unless steps are taken quickly to amend existing carrier contracts, primary insurer status might be difficult, if not impossible, to implement by January 1, 1982. This is only one of several serious administrative problems we face.

Until the Administration has better answers to these complex questions, it would be premature to support this initiative. For this reason, the Administration applauds your decision to hold hearings on this issue. I am certain that the testimony to be provided to your Subcommittee will shed much needed light on this complex question.

Sincerely,

David A. Stockman
Director



Mail Handlers Health Benefit Plan

Suite 290 North • 1800 M Street, N.W. • Washington, D.C. 20036 • (202) 223-3380

June 5, 1981

The Honorable Ted Stevens
Chairman
Subcommittee on Civil Service, Post Office
and General Services
Committee on Government Affairs
Washington, D.C. 20510

Dear Mr. Chairman:

On behalf of the Mail Handlers Union, thank you for the opportunity to submit a brief statement for the record of the hearings you held June 2, 1981, on proposed legislation to require federal health plans to assume primary health coverage for retired federal employees.

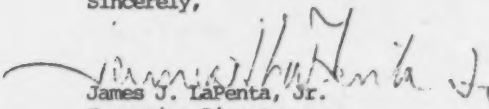
We are opposed to actions in the Senate and the House that would in any way transfer the responsibility of paying for retirees' primary health coverage from Medicare to the Federal Employees Health Benefit Program (FEHBP).

Instead, we urge maintenance of the status quo.

Our opposition to the proposals is based upon a number of factors:

1. The illusion the proposed changes are in some way "anti-inflationary." Supporters of the proposals claim the changes would save the federal government hundreds of millions of dollars. We believe otherwise. If implemented, the proposals would merely rob Peter to pay Paul.
2. The changes would have a disastrous impact on the FEHBP and its millions of enrollees. Leaving aside the continuing impact of inflation on health plan rates, the transference of responsibility from Medicare to the FEHBP would result in many plans having to raise their rates to enrollees from 40 to 100 percent.

Sincerely,


James J. LaPenta, Jr.
Executive Director

JJL/le

WILLIAM D. FORD, MICH., CHAIRMAN

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WAYNE GORDMAN, CALIF.
FRANK B. WELF, ILL.

House of Representatives.
Committee on Post Office
and Civil Service
Washington, D.C. 20515

STATEMENT OF
THE HONORABLE MARY ROSE OAKAR
CHAIR, SUBCOMMITTEE ON COMPENSATION AND EMPLOYEE BENEFITS
HOUSE COMMITTEE ON POST OFFICE AND CIVIL SERVICE
BEFORE THE
SUBCOMMITTEE ON CIVIL SERVICE, POST OFFICE, AND GENERAL SERVICES
SENATE COMMITTEE ON GOVERNMENTAL AFFAIRS
ON THE
FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM
JUNE 2, 1981

I want to express my appreciation to Senator Stevens and the Senate Subcommittee on Civil Service, Post Office, and General Services for providing me with the opportunity to testify on the Senate proposal to change the historic relationship between the Medicare Program and the Federal Employees Health Benefits Program.

As the Chair of the House Subcommittee on Compensation and Employee Benefits, I am totally opposed to this proposal as it would have the effect of changing the basic nature of the Medicare Program for federal retirees who have earned the right through social security taxes to the same level of benefits as other Americans.

Both the House Ways and Means Committee proposal and the Senate Finance Committee proposal would single out federal retirees for discriminatory treatment by reversing the existing primary and secondary payor roles of Medicare and FEHBP for individuals who are covered under both programs. The proposal approved by the Senate Finance Committee would make Medicare a secondary payor for all dual beneficiaries. The House proposal would make Medicare Part B secondary for all FEHBP dual beneficiaries, and Part A would become secondary only for new retirees.

The net result of the implementation of either of these proposals would be the transfer of a substantial amount of health care costs from Medicare to FEHBP.

Estimates of the health care costs transferred under the Senate Finance Committee proposal range all the way up to \$960 million. The effect of these proposals on the FEHBP would be catastrophic and could lead to its ultimate collapse, should the active federal employee flee those health programs with large enrollments of federal retirees--something, I am convinced, many will do.

In addition to the administrative nightmare that would result if either of these proposals are enacted, I question how much money would actually be saved. It appears to me the government would merely be transferring health care costs from one government program to another with a minimal cost savings, but with maximum harm to the FEHBP. This proposal will lead to significantly higher premiums for federal workers and retirees and will be a major incentive for thousands of federal retirees dropping their federal health insurance, thus making Medicare the primary payor anyway.

The Congress of the United States should not approve legislation which encourages older Americans to abandon their health insurance or which requires retirees to choose between the peace of mind provided by health insurance or a decent standard of living.

It is also very unfair that Congress, after mandating that the Committee on Post Office and Civil Service cut over \$5 billion from our area of jurisdiction, one of the largest cuts of any Committee, should also try through this proposal to dump an additional \$360 million "cut" on federal workers and retirees. It is unjust, and I can assure this Subcommittee that these shortsighted attacks on our federal workforce will come back to haunt the Congress.

Just this week, in testimony before three Subcommittees of the House, Mr. Jerome Rosow, the President of Work in America Institute, Inc., predicted that executive and legislative action, which has held down federal pay and other benefit reductions, will radicalize federal workers and destroy the reliability of the workforce. Senator Stevens, I think Mr. Rosow has articulated an often overlooked characteristic of the federal workforce. It is reliable, it is dependable, it can be counted on to provide high quality, consistent service to the American

people. These unprecedented cutbacks directed exclusively at federal workers and retirees undermine morale, reduce productivity, and alienate federal workers from the people they serve.

As the Chair of the House Subcommittee on Compensation and Employee Benefits, I am better aware than anyone, except possibly a federal worker or retiree, of the cumulative effect of all of these benefit reductions. I would urge this Subcommittee to reject the proposal. Medicare is an entitlement program for all eligible Americans--not all eligible Americans except federal retirees.

It is unfair to make federal workers subsidize Medicare through general tax revenue and payroll deductions for those who have made payroll contributions in covered employment--and then deny them benefits because they participate in the FEHBP.

Aside from the equity arguments, this proposal would be highly disruptive to those FEHB plans with high numbers of retirees among their subscribers. The additional costs to those plans with large numbers of federal retirees would increase premiums substantially to the retirees least able to afford it. There appears to be a misconception that federal retirees are well off and able to singlehandedly balance the federal budget. Let me assure you, that is not at all the case. Over 60 percent of federal retirees receive less than \$11,000 yearly, and almost 90 percent--88.8 percent to be exact--of all civil service survivor annuitants receive less than \$700 monthly. Surely, the Congress of the United States isn't suggesting these annuitants and survivors are so well off they should be denied Medicare coverage or should have their FEHBP premiums increased by almost 100 percent.

I would strongly urge this Committee to do everything possible to avoid transferring any additional financial burdens onto the federal worker or retiree. I respectfully ask you to do all in your power to eliminate this proposal from the reconciliation package that the Senate adopts. For my part, I pledge to do everything possible to defeat a similar House proposal. I appreciate the opportunity to provide this testimony.

STATEMENT OF

LAURENCE B. HUSTON, JR.

ASSISTANT VICE PRESIDENT
GROUP DIVISION

AETNA LIFE & CASUALTY

BEFORE THE

SUBCOMMITTEE ON CIVIL SERVICE, POST OFFICE
AND GENERAL SERVICES

OF THE

COMMITTEE ON GOVERNMENTAL AFFAIRS

JUNE 2, 1981

My name is Laurence B. Huston, Jr., Assistant Vice President, Group Division, of the Etna Life Insurance Company. I have primary responsibility for Etna's administration of the Government-Wide Indemnity Benefit Plan and, in that capacity, we are pleased to have this opportunity to comment on proposals made by the House Ways and Means Committee and by the Senate Finance Committee relative to the relationship between Medicare and the Federal Employees Health Benefits Program.

It is our understanding that the House Ways and Means Committee proposes that, as of January 1, 1982, coverage under FEHBP would become primary with respect to Part B of Medicare and, further, with respect to those federal enrollees and their dependents who become eligible for Medicare due to attainment of age 65 on and after January 1, 1982, the FEHB carrier would pay its regular plan benefits without regard to any Medicare benefits for which the individual might be eligible. It is our understanding that the Senate Finance Committee proposes that the federal program become primary on January 1, 1982 for all persons who are eligible for benefits under both programs.

We would first observe that the intent of Congress has always been to regard Medicare as an entitlement program. Under the current proposals, Medicare would remain an entitlement program for most Americans, but not for Medicare-eligible employees of the federal government and their Medicare-eligible dependents.

Whether or not Medicare should be an entitlement program is a question that we do not propose to address today. My Company does not philosophically

oppose the concept of transfer of coverage, or at least primary responsibility for coverage, from various public programs to the private sector. We believe, however, that such transfer should recognize the need to avoid "double taxation" caused by holding employers and employees responsible both for taxes to finance present public benefits and for premiums to finance future private benefits.

With these preliminary remarks we will now address the specifics of the current proposals. First, we would observe that these proposals would increase the total cost of health care benefits for federal employees. This is so for two reasons. First, we do not believe it is the intent of Congress to reduce the total benefit dollars paid for Medicare and FEHB combined. However, the cost of administering Medicare and possibly FEHB will increase significantly. Although we cannot provide an exact dollar amount for these increased administrative costs at this time, we believe they could represent a significant portion of the estimated \$71 million net savings estimated by the House Ways and Means Committee. Thus, we are talking not about a true cost reduction, but rather, about a cost shift plus additional expenses resulting from that shift.

Second, the shift of primary responsibility for Medicare eligibles from Medicare to FEHB would require significant premium rate increases for both the high and low options of the Government-Wide Indemnity Benefit Plan. Approximately 40% of these increased premium rates would be assumed by all federal employees and their dependents enrolled under our Plan. I would emphasize the word all, because this contribution rate increase would apply not just to Medicare eligibles, but, according to present law and regulation, would apply to all enrollees.

For example, with respect to the Senate Finance Committee's proposal, we estimate that our low option premium rate for Self Only would increase by more than 150% independent of inflation in health care costs. Under the Ways and Means proposal, the Self Only rate for our low option plan would increase almost 50%. The effect on our other premium rates would be somewhat less dramatic. Nevertheless, when combined with anticipated future inflation in the cost of health care, a major additional financial burden would be placed on all enrollees in the Government-Wide Indemnity Benefit Plan.

We remind the Committee that all of this activity is taking place at a time when we are in the process of finalizing our estimated premium requirements for calendar year 1982. Our rate proposal must be submitted to the Office of Personnel Management by July 30th and negotiations must be concluded by September in connection with the forthcoming open season. The sum and substance of our concern is that for the first time in more than 20 years, we may have to establish rates before we are certain about pending Congressional action. We expect that all other plans will find themselves in a similarly awkward position. We fear that the open season may become chaotic for the first time ever and that the effects of this disruption will be felt by both enrollees and carriers for many years to come.

We applaud Congressional efforts to reduce government outlays. We understand that the Medicare program cannot be and should not be immune from these efforts. However, we are concerned that these particular proposals may be based, at least in part, on an erroneous assumption that federal

government funds being expended under the Federal Employees Health Benefits Program for persons who have qualified for Medicare eligibility either through service in the private sector or through their spouses' service in that sector are comparable to federal funds expended on behalf of all other enrollees and their dependents.

The Government-Wide Indemnity Benefit Plan does not duplicate the benefits of Medicare, but rather supplements them. Because of this, the Government is not contributing 70% of the cost of benefits for Medicare eligibles as is true for the average enrollee. Actually, the Government is contributing only 45%.

Finally, while we have discussed without quantification the significant additional administrative expenses which will be incurred by Medicare carriers and intermediaries, and by all of the Federal Health Benefits Plans and the Office of Personnel Management, our concern goes beyond the cost involved. Significant regulation would presumably be required, and it is entirely possible that the net result will be either benefit increases or benefit reductions for the enrollees involved. Under the Ways and Means Committee's proposal, all FEHBA plans will have to know whether Medicare eligibles became eligible for Medicare before or after January 1, 1982. Our source for this information and how timely notification will be are questions which we do not believe anyone has addressed or answered as yet. Furthermore, while it is easy to say that we will coordinate with Medicare Part A and Medicare will coordinate with that portion of our benefit which is reflective of the benefits of Part B, these approaches may be extremely

difficult to administer. And where does the enrollee go first for claim payment? Does he come to the FEHB carrier, or does he go to Medicare? There are myriad questions surrounding what may appear to be a simple concept, and the answers to some of these questions may require many months of negotiation and many pages of complex regulation.

In summary, we must caution against a precipitous change in the relationship between Medicare and the Federal Employees Health Benefits Program. We think the changes contemplated here are not in the interests of enrollees, or of the plans participating in the Federal Employees Health Benefits Program, and are not likely, in the long run, to contribute to reductions in federal outlays. We do believe that Congress should examine the broad question of whether Medicare should continue to play such a dominant role in providing benefits that could be provided by the private insurance coverage. As I said earlier, however, the complexities of changing the present interrelationship require much more time than is available during the current budget deliberations. We stand ready to work with appropriate committees in Congress to examine this important issue in the future.

I thank the Committee for the opportunity to testify and I shall be pleased to answer any questions you may have.

AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES

Affiliated with AFL-CIO

1325 Massachusetts Avenue, N.W., Washington, D. C. 20005



STATEMENT OF

KENNETH T. BLAYLOCK
NATIONAL PRESIDENT

AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES

BEFORE THE

SENATE SUBCOMMITTEE ON CIVIL SERVICE

GOVERNMENTAL AFFAIRS COMMITTEE

ON THE

FEDERAL EMPLOYEE HEALTH BENEFITS PROGRAMS

JUNE 2, 1981

The American Federation of Government Employees, which represents over 700,000 Federal workers, is pleased to appear and testify before this Subcommittee to address an issue of great concern to our membership.

The Senate Finance Committee has recommended a fundamental shift in the structure of Medicare which has ominous and far reaching implications for the future integrity of the program. The recommendation was made as part of the effort to meet spending reduction targets contained in the First Budget Resolution for FY 1982.

Briefly, the Committee has proposed that Medicare no longer be the primary payor for Federal annuitants and their survivors who are eligible for benefits under parts A and B. Rather, the Federal Employee Health Benefits Plan would assume the role of

primary payor, and Medicare would be shifted to secondary payor status. No similar change would be made for any non-Federal employee health insurance program.

AFGE has examined this proposal, and it appears to make little sense either in terms of Government economy, efficient health plan administration, or fairness to Federal workers.

Let me illustrate. The Senate Finance Committee, in taking this action, estimates a reduction in Medicare outlays of 960 million dollars in FY 1982 and 1.1 billion dollars in FY 1983. They estimate, however, that net savings to the Federal government would amount to only 390 million dollars in FY 1982 and 440 million dollars in FY 1983, due to the fact that the government as an employer would be required to absorb much greater premium costs as rates increase.

AFGE believes the Committee has failed to take into account the substantial "hidden costs" associated with this recommendation.

First, the FEHB carriers will be required to renegotiate plan coverage this year with the Office of Personnel Management. Negotiations for new coverage to go into effect in January, 1982 had already been completed. Since the shift in primary health coverage can be expected to cause turbulence in the entire FEHB program, the OPM, the carriers, unions and employees will all need time to consider the import of the changes and calculate the effects on rates and coverage. OPM has already testified severe dislocations and administrative problems will emerge if this proposal is implemented.

Second, although Medicare costs will decline in the short run, there is some evidence that over the next few years these initial savings will be offset by the costs of assuming primary coverage for

Federal annuitants who drop participation in the FEHB program. This will occur because the Committee proposal will have the effect of dramatically raising the premiums in FEHB plans that have a disproportionately large number of Medicare enrollees, who could then be priced out of their Federal coverage.

The six largest FEHB plans cover approximately 90% of Federal Medicare enrollees. We do not believe anyone can accurately forecast the impact of the proposal on FEHB premiums. But we know that as these rates go up in the major plans, it can be anticipated that younger participants will drop out for other, low-option plans thus setting off a new round of premium increase for those who remain behind. At some point, it is likely that many of these Medicare enrollees would drop their FEHB plans as being too expensive and rely exclusively of Medicare for primary coverage. Medicare costs, of course, would then begin to rise back to their original levels.

The Committee recommendation seems to make little sense in terms of cost effectiveness. There is a final concern, however that AFGE would like to emphasize. We believe this proposal represents a radical departure from the principles on which Medicare has rested since its inception. Congress clearly intended Medicare to be primary insurer for all participants, without regard to whether or not an individual has additional health insurance from another source. However, the Senate Finance Committee has decided to segregate an undetermined number of Federal civil service annuitants from the program even though they have paid the Hospital Insurance Tax over the years and are eligible for Medicare benefits. Such a recommendation sets a very dangerous precedent.

In short, it appears to us as though the Senate Finance Committee, perhaps inadvertently, has found a "back-door" way to dismantle the Medicare program, and to shift primary responsibility for Health Insurance coverage to the private sector. Inevitably, Medicare would become no more than a supplementary program for whole categories of workers who are also covered by private plans.

AFGE believes that Congress should not attempt to restructure Medicare on a piece-meal basis at a time when so much uncertainty surrounds the future of the Social Security program. Most importantly, the relatively small number of Federal personnel who are eligible for Medicare coverage should not be singled out for this departure from current and long-standing policy.

We request Congress to take no precipitate action in this matter.



American Postal Workers Union, AFL-CIO

817 14TH STREET, N. W., WASHINGTON, D. C. 20005

STATEMENT
OF THE
AMERICAN POSTAL WORKERS UNION, AFL-CIO
BEFORE THE
SUBCOMMITTEE ON CIVIL SERVICE
OF THE
COMMITTEE OF GOVERNMENTAL AFFAIRS

JUNE 2, 1981

MY NAME IS MOE BILLER, GENERAL PRESIDENT OF THE AMERICAN POSTAL WORKERS UNION, AFL-CIO.

THE AMERICAN POSTAL WORKERS UNION REPRESENTS APPROXIMATELY 315,000 POSTAL WORKERS. THE AMERICAN POSTAL WORKERS HOSPITAL PLAN WAS CREATED IN 1970 WHEN THE APWU WAS FORMED BY THE MERGER OF FIVE POSTAL UNIONS, TWO OF WHICH HAD THEIR OWN HEALTH BENEFITS PLANS. THE APWU PLAN PROVIDES A BROAD RANGE OF IN-HOSPITAL, OUT-OF-HOSPITAL, SURGICAL, MEDICAL, DENTAL AND PRESCRIPTION DRUG BENEFITS TO 215,000 ENROLLEES AND THEIR 350,000 FAMILY MEMBERS. MOST OF OUR ENROLLEES ARE EMPLOYEES OR RETIREES OF THE U. S. POSTAL SERVICE. THE BALANCE OF OUR ENROLLEES IS MADE UP OF OTHER FEDERAL WORKERS WHO HAVE JOINED THE PLAN THROUGH "OPEN SEASON" ENROLLMENT. OUR PLAN IS ENTIRELY UNDERWRITTEN BY THE AMERICAN POSTAL WORKERS UNION AND OPERATES UNDER A CONTRACT WITH THE FEDERAL OFFICE OF PERSONNEL MANAGEMENT.

OUR PLAN IS, OF COURSE, AN EMPLOYEE ORGANIZATION PLAN ESTABLISHED UNDER SECTION 8903 OF TITLE 5 OF THE U. S. CODE. IT IS A CONTRIBUTORY PLAN, WITH THE POSTAL SERVICE AND THE COVERED EMPLOYEES MAKING PROPORTIONAL CONTRIBUTIONS TO PAY THE COST OF HEALTH INSURANCE PREMIUMS. IT IS AN EXPERIENCE-RATED PLAN, IN THAT THE FUNDS RECEIVED THROUGH PREMIUMS ARE

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USED TO PAY THE HEALTH CARE EXPENSES OF THE PLAN MEMBERS; AND IT IS OPERATED ON A NON-PROFIT BASIS. OUR PREMIUM RATES ARE ESTABLISHED EACH YEAR THROUGH A PROCESS OF NEGOTIATIONS WITH THE OFFICE OF PERSONNEL MANAGEMENT. PREMIUM INCREASES REFLECT IMPROVED BENEFITS, INFLATION, AND ANY MANDATORY CHANGES REQUIRED BY AMENDMENT OF FEDERAL LAW.

MR. CHAIRMAN, AND MEMBERS OF THE COMMITTEE, I APPRECIATE THE OPPORTUNITY YOU HAVE GIVEN US TO APPEAR TODAY TO PRESENT OUR VIEWS ON PROPOSALS MADE BY OTHER COMMITTEES OF CONGRESS TO REVERSE THE EXISTING PRIMARY AND SECONDARY PAYOR ROLLS OF MEDICARE AND FEDERAL HEALTH INSURANCE BENEFITS, FOR INDIVIDUALS WHO ARE COVERED UNDER BOTH PROGRAMS. AS YOU HAVE ALREADY HEARD THROUGH OTHER TESTIMONY, THE PROPOSAL TO MAKE FEDERAL HEALTH BENEFIT PLANS THE PRIMARY PAYOR FOR INDIVIDUALS WHO ARE COVERED BY BOTH MEDICARE AND FEDERAL HEALTH BENEFITS WOULD HAVE A DRASTIC IMPACT ON THE FEDERAL HEALTH BENEFIT PLANS. AS THE DIRECTOR OF THE OFFICE OF PERSONNEL MANAGEMENT HAS TOLD YOU, FEDERAL HEALTH BENEFIT PLAN ENROLLEES WHO ARE ELIGIBLE FOR MEDICARE ARE NOT EVENLY DISTRIBUTED AMONG THE PLANS. ACCORDING TO OPM DIRECTOR DEVINE, THEY ARE CONCENTRATED IN THE THREE OR FOUR LARGEST HEALTH INSURANCE PLANS. THOSE PLANS WOULD, ACCORDING TO MR. DEVINE, HAVE TO INCREASE THEIR PREMIUMS SOME 21% TO COVER THE INCREASED EXPENSE OF PROVIDING PRIMARY COVERAGE FOR THOSE ELIGIBLE FOR MEDICARE, WITH SOME PARTICULAR PLANS WITH HEAVY CONCENTRATIONS OF RETIREES INCREASING PREMIUMS BY MORE THAN 70%.

WITHOUT BELABORING THE POINTS MADE BY MR. DEVINE, I DO WANT TO EMPHASIZE THAT THIS WILL RESULT IN SERIOUS DISTORTIONS IN RATES BETWEEN DIFFERENT HEALTH BENEFIT PLANS, WITH VERY ADVERSE EFFECTS ON THE EXPERIENCE OF PLANS WITH RELATIVELY HEAVY CONCENTRATIONS OF MEDICARE ENROLLEES. THE RESULTING

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INCREASES IN PREMIUMS WILL CAUSE YOUNGER EMPLOYEES TO SEEK COVERAGE BY BENEFIT PLANS WHICH DO NOT BEAR THE BURDEN OF PAYING BENEFITS COVERED BY MEDICARE. THESE EFFECTS WOULD MOST LIKELY BE QUITE DRAMATIC IN THE FIRST FEW YEARS FOLLOWING THE CHANGE THAT HAS BEEN PROPOSED. BUT, EVEN IN LATER YEARS, PLANS WITH RELATIVELY HIGH CONCENTRATIONS OF MEDICARE ENROLLEES WOULD BE DISADVANTAGED, BECAUSE OF THE HIGHER UTILIZATION RATES THAT OCCUR AS INDIVIDUALS BECOME OLDER.

IN THE CASE OF THE APWU HOSPITAL PLAN, WE HAVE, AS I HAVE TOLD YOU, 215,000 PLAN MEMBERS. OF THAT MEMBERSHIP, OVER 41,000 ENROLLEES ARE ALSO COVERED BY MEDICARE. DURING OUR FISCAL YEAR ENDING DECEMBER 31, 1980, OUR ENROLLEES WHO ARE ALSO ENROLLED UNDER MEDICARE FILED CLAIMS FOR BENEFITS TOTALLING OVER 50 MILLION DOLLARS. OF THIS AMOUNT, OUR HOSPITAL PLAN PAID 7.2 MILLION DOLLARS, AND THE BALANCE OF APPROXIMATELY 43 MILLION DOLLARS WAS EITHER PAID BY MEDICARE OR NOT COVERED BY EITHER OUR PLAN OR MEDICARE.

OUR PLAN IS ONE IN WHICH THE PROPOSAL TO MAKE FEDERAL EMPLOYEE HEALTH BENEFITS PLANS THE PRIMARY PAYORS FOR INDIVIDUALS ALSO COVERED BY MEDICARE WOULD HAVE A DRASTIC EFFECT. WE CANNOT STATE THE DOLLAR IMPACT EXACTLY, BECAUSE THE PREMIUM FORMULA WILL REFLECT THE IMPACT OF THIS PROPOSAL ON OTHER PLANS. BUT, REASONABLY ACCURATE PREDICTIONS CAN BE MADE.

OUR PREMIUM RATE THIS YEAR, FOR OUR BENEFIT PACKAGE COVERING INDIVIDUALS AND THEIR FAMILIES, IS \$61.10 FOR EACH BI-WEEKLY PAY PERIOD. IF THE SENATE FINANCE COMMITTEE PROPOSAL IS ADOPTED, THESE PREMIUMS WOULD HAVE TO BE INCREASED 17.6% FOR 1982, JUST TO COVER THE INCREASED PAYMENTS WE WOULD HAVE TO MAKE TO MEDICARE BENEFICIARIES. THE DOLLAR INCREASE, FOR EACH BI-WEEKLY PAY PERIOD, WOULD BE \$10.75. OF THIS AMOUNT, INDIVIDUALS WOULD HAVE TO PAY \$2.69 FOR EACH BI-WEEKLY PAY PERIOD, OR NEARLY \$70 PER YEAR. THE POSTAL SERVICE WOULD HAVE TO PAY \$8.06 FOR EACH BI-WEEKLY PAY PERIOD, WHICH IS OVER \$209 PER YEAR FOR EACH OF OUR SUBSCRIBERS.

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THE IMPACT ON OUR MEMBERS WHO ARE COVERED UNDER OUR SELF-ONLY COVERAGE PLAN WOULD BE EVEN MORE DRAMATIC. THE INCREASE FOR THESE INDIVIDUALS FOR 1982 WOULD BE 48.5%, JUST TO PAY THE INCREASE IN PREMIUM THAT WOULD BE REQUIRED BY THE SENATE FINANCE COMMITTEE PROPOSAL. IN DOLLARS, THE INCREASE IN BI-WEEKLY PREMIUM WOULD BE \$12.25. OF THIS AMOUNT, INDIVIDUALS WOULD HAVE TO PAY \$3.06 FOR EACH BI-WEEKLY PAY PERIOD, WHICH IS NEARLY \$80 PER YEAR. THE POSTAL SERVICE WOULD HAVE TO PAY, FOR EACH INDIVIDUAL, \$9.19 PER BI-WEEKLY PAY PERIOD, WHICH IS APPROXIMATELY \$240 PER YEAR.

WHEN THESE NUMBERS ARE MULTIPLIED BY THE 215,000 MEMBERS OF OUR HEALTH BENEFIT PLAN, THE TOTAL COST TO OUR PLAN, TO ITS INDIVIDUAL MEMBERS, AND TO THE POSTAL SERVICE, IS TRULY STAGGERING. THERE CAN BE NO DOUBT THAT OUR YOUNGER MEMBERS WILL BE MOTIVATED TO SEEK OTHER PLANS WHICH ARE NOT AS SEVERELY IMPACTED BY THE PAYMENT OF MEDICARE BENEFITS.

IT IS MY UNDERSTANDING THAT THE COST OF THIS PROPOSAL TO THE POSTAL SERVICE, IN THE AGGREGATE, WILL BE APPROXIMATELY 100 MILLION DOLLARS. APART FROM ANY OTHER CONSIDERATIONS, LET ME SAY THAT IT WOULD BE VERY UNFORTUNATE TO IMPOSE THIS LARGE BURDEN ON THE POSTAL SERVICE AT THIS TIME. AS YOU KNOW, THE ALREADY LARGE REDUCTIONS IN THE POSTAL SERVICE SUBSIDY PROPOSED BY THE CARTER ADMINISTRATION ARE GOING TO BE INCREASED, CUTTING VERY DEEPLY INTO POSTAL SERVICE REVENUES. THE POSTAL SERVICE HAS RECENTLY BEEN DENIED THE POSTAGE INCREASES IT BELIEVES NECESSARY TO MEET ITS FINANCIAL NEEDS, AND POSTMASTER GENERAL BOLGER HAS ALREADY PREDICTED AN EARLY RETURN TO THE POSTAL RATE COMMISSION SEEKING EVEN HIGHER INCREASES IN POSTAGE RATES.

WE ARE ALSO FACING THE JULY 20, 1981 EXPIRATION OF OUR COLLECTIVE BARGAINING AGREEMENT WITH THE POSTAL SERVICE. AS YOU MAY KNOW, POSTMASTER GENERAL BOLGER HAS REFUSED TO BARGAIN

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WITH THE LONG-ESTABLISHED UNIONS THAT REPRESENT POSTAL EMPLOYEES AND HAS SOUGHT TO DELAY BARGAINING INDEFINITELY BY LITIGATING BEFORE THE NATIONAL LABOR RELATIONS BOARD. IT WOULD APPEAR THAT PART OF HIS MOTIVATION HAS BEEN TO AVOID WHAT PROMISES TO BE A DIFFICULT ROUND OF COLLECTIVE BARGAINING NEGOTIATIONS AT THIS TIME, IN LIGHT OF OTHER SUBSTANTIAL PRESSURES ON THE POSTAL SERVICE. NEVERTHELESS, THE POSTAL SERVICE IS OBLIGATED BY LAW TO BARGAIN WITH THE DULY CONSTITUTED REPRESENTATIVES OF ITS EMPLOYEES, AND WE ARE ACTIVELY SEEKING THROUGH THE PROCESSES OF THE NATIONAL LABOR RELATIONS BOARD TO BRING THE POSTAL SERVICE TO THE BARGAINING TABLE.

THIS IS, OF COURSE, NOT THE PRIMARY CONCERN REGARDING THIS PROPOSAL TO REQUIRE FEDERAL HEALTH BENEFIT PLANS TO BE THE PRIMARY PAYOR FOR MEDICARE RECIPIENTS. BUT, IT IS A FACTOR THAT WE ALL MUST BEAR IN MIND. THIS IS PARTICULARLY TRUE BECAUSE THE POSTAL SERVICE HAS ITS OWN BUDGET--IT IS NOT, THEREFORE, ABLE TO PARTICIPATE IN ANY SAVINGS THAT MIGHT ACCRUE TO THE BENEFIT OF THE FEDERAL GOVERNMENT BY SEEKING CONSIDERATION IN ITS BUDGET REQUESTS FOR THE 100 MILLION DOLLARS IT WOULD BE REQUIRED TO PAY UNDER THIS PROPOSAL.

IN THIS REGARD, THE POSTAL SERVICE IS MUCH MORE LIKE A PRIVATE EMPLOYER THAN A GOVERNMENT AGENCY. IT IS MY UNDERSTANDING THAT THERE IS NO PROPOSAL TO REQUIRE PRIVATE INDUSTRY TO BECOME THE PRIMARY HEALTH INSURANCE PAYOR FOR THEIR INDIVIDUAL EMPLOYEES COVERED BY MEDICARE. THUS, THE POSTAL SERVICE IS BEING PENALIZED BY A 100 MILLION DOLLAR LIABILITY BUT, LIKE OTHER PRIVATE SECTOR EMPLOYERS, IT HAS NO OPPORTUNITY TO OBTAIN RELIEF FROM THIS COST THROUGH A REALIZATION OF THE SAVINGS TO THE FEDERAL TREASURY WHICH WILL RESULT.

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EVEN MORE IMPORTANT, AS FAR AS WE ARE CONCERNED, IS THE UNFAIRNESS OF REQUIRING INDIVIDUAL PLAN MEMBERS TO BEAR EITHER A 17.6% OR 48.5% INCREASE IN THEIR HEALTH INSURANCE PREMIUMS, JUST TO PAY FOR THIS SAVINGS TO THE FEDERAL GOVERNMENT. IT WOULD BE PRECIPITOUS, IN MY VIEW, TO IMPOSE THIS LARGE INCREASE ON INDIVIDUAL PLAN MEMBERS WITHOUT FULLER STUDY AND CONSIDERATION THAN HAS BEEN GIVEN THIS PROPOSAL.

AS YOU HAVE HEARD FROM OTHER WITNESSES, THE DISLOCATIONS THAT WOULD RESULT IN THE FEDERAL EMPLOYEES HEALTH BENEFIT PROGRAM ARE INCALCULABLE AT THIS TIME. I KNOW THAT OPM DIRECTOR DEVINE EXPRESSED CONCERN THAT THE CHANGE WOULD "SET OFF A NEW ROUND OF PREMIUM INCREASES FOR PLANS WITH A DISPROPORTIONATE SHARE OF OLDER AND MORE EXPENSIVE ENROLLEES UNTIL THE ENTIRE FEHB PROGRAM COLLAPSES." AND HE HAS SUGGESTED THAT LEGISLATION TO REDESIGN THE FEHB PROGRAM WOULD BE NECESSARY, TO ESTABLISH A SEPARATE, MORE EXPENSIVE PLAN FOR OLDER ENROLLEES. THIS WOULD, OF COURSE, CREATE PRESSURES FOR THOSE ENROLLEES TO ABANDON THE FEHB PROGRAM ALTOGETHER. THE RESULT, WE BELIEVE, WOULD BE THAT THE FEDERAL GOVERNMENT WOULD FIND THAT ANY SAVINGS RESULTING FROM THIS PROPOSAL WOULD BE OFFSET BY HIGHER PREMIUMS PAID BY FEDERAL AGENCIES FOR HEALTH BENEFITS, AND WOULD IMPOSE A VERY HIGH COST IN TERMS OF DISRUPTIONS TO THE FEDERAL HEALTH BENEFITS PROGRAM.

THANK YOU, AGAIN, MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE FOR GIVING US THIS OPPORTUNITY TO TESTIFY. WE WILL BE HAPPY TO ANSWER ANY QUESTIONS YOU MAY HAVE.

A Statement By The
BLUE CROSS AND BLUE SHIELD ASSOCIATIONS

Prepared For
THE SUBCOMMITTEE ON CIVIL SERVICE, POST OFFICE
AND GENERAL SERVICES
COMMITTEE ON GOVERNMENTAL AFFAIRS

June 2, 1981

Mr. Chairman and members of the committee, my name is James N. Gillman. I am Vice President of the Federal Employee Program for the Blue Cross and Blue Shield Associations. The Government-wide Service Benefit Plan is underwritten by Blue Cross and Blue Shield Plans and has 1,822,077 contracts insuring 5,101,944 federal employees, annuitants and their dependents. I welcome the opportunity to appear before this Subcommittee to express our concerns regarding the changes in the relationship between Medicare and the Federal Employees Health Benefits Program (FEHBP).

The Blue Cross and Blue Shield Associations are concerned that the legislation regarding changes in the coordination of health benefits claims between Medicare and the FEHBP will be detrimental to both the government and its employees.

Currently, Medicare is the primary payor for all Medicare recipients, which means that Medicare pays its benefits first, and any additional insurance the person may have usually covers balances not paid by Medicare. This is true for all Medicare recipients, whether they are retired federal employees or retirees from private industry. As we understand the Senate legislation, the Medicare program Parts A and B will become the secondary payor for health care claims of federal retirees who are covered under both an FEHBP plan and Medicare. This means that the FEHBP carrier would pay

its benefits first, and any balances for covered services would be paid by Medicare. This change is being made as part of the recommendations to cut government spending for Medicare.

We believe that the proposal is inequitable to retired federal employees who are eligible for Medicare since they have met the same eligibility requirements as their fellow citizens in private industry. These retired federal employees have paid the Hospital Insurance Tax for Part A and paid the monthly purchase price for Part B as have all other individuals eligible for Medicare; but retired federal employees would be denied equal Medicare benefits because they have maintained their FEHBP coverage after working for the federal government for 5 years or more. They are entitled to the same Medicare benefits as other eligible retirees. The proposed change, which would cause an increase in the FEHBP plan premiums, would impose a financial burden on both federal employees and retirees--a burden from which private industry retirees are exempted.

This Senate legislation will seriously affect the financial position of the FEHBP. Currently, the funds that are not expended by the FEHBP as a result of Medicare's primary payment, help offset the cost of the health care coverage for all federal employees and retirees. Eliminating the Part A and B Medicare primary benefits would necessitate

substantial premium rate increases for the FEHBP plans that cover large numbers of federal retirees. The six carriers, whose rates determine the government contribution to the health benefits premiums, cover more than 90 percent of all federal retirees. Because Medicare is primary under current law, the FEHBP premiums have been calculated on the basis of providing coverage which supplements Medicare. Therefore, changing Medicare from primary to secondary payor to FEHBP coverages would increase substantially the premiums in FEHBP. Since these premiums are in part paid by federal employees and in part paid by government contributions, there would be an increase in costs to both the federal employee and the government. Rather than resulting in a major cost savings for the government and taxpayer, this change would result in a cost transference from one government program to another with additional out of pocket expenses for federal employees.

It is difficult to determine the overall effect this legislation would have on the FEHBP because it depends on the individual reaction of the federal employees in the program. We believe the premium increase due to the changes in the primary/secondary relationship of Medicare and FEHBP would range from 20% to as high as 100% in some rate categories of the FEHBP. This would be in addition to the increase required because of inflation of cost and utilization trends. Such an increase

would influence employees and annuitants who are lower utilizers of health service to enroll in plans with lower premiums thereby resulting in a need for still higher premiums in those plans with large percentages of members who use more health services. This shifting among plans will exacerbate the adverse selection which is affecting some plans at this time. This cycle could well continue until some carriers would no longer be viable. It could bring about the deterioration of the entire FEHBP. Such a cycle would certainly undermine the well-founded and highly regarded federal employee health insurance program.

Also, we believe the Subcommittee should be aware that many retired federal employees with Medicare will not be willing to continue to pay the high FEHBP premiums and will drop this coverage, thereby, relying solely on Medicare for their health insurance coverage. Certainly this type of reaction will decrease any anticipated savings in Medicare expenditures. It also should be noted that federal retirees not eligible for Medicare and on rather fixed incomes would of course have to retain their FEHBP coverage and endure the significant premium increases. These federal retirees would be among those shifting in and out of FEHBP plans in an effort to help reduce their out of pocket costs for health insurance.

Although these major effects on FEHBP premium rates would occur in the first year, we believe that premium rates would

escalate more rapidly than usual under the proposed changes. Since annuitants as a group are high users of health care services, and the annuitant population is increasing, while active federal employment levels are expected to decrease, FEHBP premiums would reflect the entire cost of covering a growing population of high health care utilizers. In sum, the government contribution would increase at a rate much faster than in recent years. In order for the government to remain competitive with private industry for talented workers, it would not be prudent for the government to freeze or decrease its contribution for health benefits, therefore this legislation would result in increased government costs for FEHBP.

In addition to the inequity to active and retired federal employees and the significant increases in FEHBP premiums, we believe there are serious administrative concerns which need to be examined. Medicare contractors, beneficiaries and providers will face complicated and confusing claims filing, processing and payment procedures.

Medicare carriers and intermediaries now have a relatively simple processing function. First, they must determine Medicare eligibility and second, they pay Medicare benefits. Under the new legislation, this process will be somewhat more complex. The processors will have to first, determine

Medicare eligibility; second, determine if there is FEHBP eligibility; third, determine FEHBP benefits; and fourth, determine Medicare payments. The determination of FEHBP eligibility and payment could be confusing and time consuming for Medicare contractors since not all Medicare eligible federal retirees will have retained the FEHBP coverage. In cases where the Medicare beneficiary has kept the FEHBP insurance, the Medicare processor will be coordinating benefits with as many as 120 different FEHBP carriers. There will be many different benefit payment levels including usual, customary, reasonable, and prevailing levels of reimbursement, varying fee schedules, a variety of deductibles and coinsurances, different covered services, and different procedure coding and nomenclature. Since there is such a great variety of benefit scopes and levels in the FEHBP plans and since not all plans provide a statement of the benefits paid, it appears that Medicare contractors will be burdened with extensive communication activities with FEHBP plans and retired federal employees to verify the precise benefit payments made by the FEHBP plans. We believe this will contribute to longer processing times for Medicare claims, increase the amount of communications and complaints for Medicare contractors, perhaps require additional Medicare claims processing and beneficiary services staff and most certainly add to the administrative costs for Medicare carriers and intermediaries.

We suggest that these administrative ramifications resulting from this legislation need further analysis particularly at a time when the Health Care Financing Administration is proposing reductions and conservation in administrative funds available to Medicare contractors. It is inconceivable that those contractors should be burdened with the additional administrative work related to the processing of Medicare claims in coordination with FEHBP and not incur additional administrative costs which should be reimbursed by the Medicare program.

Medicare beneficiaries and providers will also have increased problems in filing claims and receiving reimbursement since many hospitals and physicians will find it confusing to file claims for the federal retirees with Medicare in a way that is different from the usual Medicare beneficiary. Today, the provider and the Medicare beneficiary look with assurance to the Medicare program when services are rendered. Under the new legislation, that solid assurance will be undermined. Because of the great potential for misinformation and confusion on the part of patients and providers, claims will be sent to the wrong insurer; claims correctly sent will be erroneously returned; providers may or may not be willing to file claims for the patient; after receiving payment from one program, providers may be unwilling to file with the second insurer, thus the retiree or beneficiary will have to file the second claim; and the patients and

providers will be confused about which insurer paid how much for which service. Patients and providers most certainly will communicate more with the insurers in an effort to find the answers. Many providers will become more frustrated with the Medicare program and much discontent and dissatisfaction will result for all concerned. All of these problems make an already complex Medicare program even more confusing for persons who in truth need a more simplified program.

We should call your attention to still another serious disadvantage which Medicare eligible federal retirees will face. The Blue Cross and Blue Shield Federal Employee Program (FEP) and other FEHBP plans currently provide benefit liberalizations, such as not imposing the FEHBP plans' deductible and/or coinsurance, for retirees with Medicare. This enables the retired federal employee with Medicare to receive maximum benefit coverage for the health care expenses incurred. This is similar to situations in private industry where those retirees have coverage which completely fills the gaps in Medicare coverages. These complementary type programs do not have deductibles and coinsurances. The existing combination of FEHBP plans with waivers for deductibles and coinsurances and Medicare providing primary benefits puts the federal retirees on par with the retiree from private industry. Under the new legislation, FEHBP carriers will not be able to afford to waive the deductible and

coinsurances and, since Medicare will still apply its deductibles and coinsurances, the federal retiree will suffer considerable increase in out of pocket medical expenses in addition to the increase in out of pocket premium cost. Many retired federal employees on limited fixed incomes will not be able to bear the burden of these increased expenses. As stated before, since many federal retirees are not eligible for Medicare, they will of course have to remain in the FEHBP, and those with Medicare will probably opt out of the FEHBP.

We submit that this Subcommittee should be alert to the fact that transferring benefit payouts from the Medicare program to FEHBP, increasing the total dollars of the government contribution under FEHBP (because of its share in FEHBP premiums), Medicare eligible federal retirees discontinuing their FEHBP coverage, and the increased administrative costs for Medicare contractors significantly erodes the savings to the federal government which have been projected for this legislation. We would hope that the Congress will fully address the issue of whether the inequity to federal retirees and the disorder to the Medicare and FEHB Programs is truly worth the final savings.

With respect to action proposed in the House to make FEHBP primary to Medicare Part B for all federal retirees and to Part A for new retirees, our assessment is that the effects on FEHBP premiums of such a change will be similar in nature

to, but of a lesser degree than, those mentioned in regard to the Senate legislation. Also, we concur with a position expressed by a Health and Human Services official that the administrative costs of the House proposal might be so great that there would be no savings to the government in the first year of the plan. In fact, the administrative problems related to the House proposal may be even greater than those mentioned above relating to the Senate legislation. Both Medicare contractors and FEHBP plans will have to establish resources and mechanisms for identifying Medicare eligible federal retirees and, in addition, both processors will have to have mechanisms for identifying dates of eligibility for federal retirees who become Medicare A beneficiaries. This will add to the administrative costs of Medicare contractors and FEHBP plans and the federal government.

We appreciate the opportunity to share our concerns about this issue with you and we hope that due consideration will be given to the several points which we have presented. We would be pleased to work with the Subcommittee on further analysis of this issue. I will be happy to answer any questions you may have. Thank you Mr. Chairman.

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Vice President
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Secretary-Treasurer
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STATEMENT
of the
NATIONAL ASSOCIATION OF LETTER CARRIERS
before the
SUBCOMMITTEE ON CIVIL SERVICE, POST OFFICE AND GENERAL SERVICES
of the
COMMITTEE ON GOVERNMENTAL AFFAIRS
June 2, 1981

My name is Tony R. Huerta, Executive Vice President of the National Association of Letter Carriers. With me here today are Robert J. Buntz, Director of Health Insurance; Anthony R. Morell, Assistant Director of Health Insurance, and George B. Gould, Legislative Assistant to the President.

The National Association of Letter Carriers, AFL-CIO, a Union representing approximately 240,000 Letter Carriers of which 55,000 are retired Letter Carriers, is the exclusive bargaining agent for city delivery carriers employed by the U.S. Postal Service. We appreciate the opportunity to appear today and share with the Committee our concerns about proposed changes in the Federal Employee Health Benefit Plans.

The current NALC Health Benefit Plan is a negotiated plan between the NALC and the U.S. Office of Personnel Management. The Plan

is a contributory plan, as both Union members and the Federal Government contribute to it. The plan is an experienced-rated plan, in that all of the funds received are used to pay the health care expenses of the members of the NALC. It is operated on a nonprofit basis. Premium rates are established each year by the Health Benefit Plan and are negotiated to include increased benefits, inflationary and administrative costs and any mandatory changes that result through Federal law.

Congress has recently considered two proposals to change the relationship between Medicare and Federal Employee Health Benefit Plans. These proposed changes are to make Medicare the secondary payor to the Health Benefit Plans, which are currently the secondary payor. As you know, Mr. Chairman, the Senate Finance Committee, as part of the Reconciliation package, reported out legislation that would make the FEHB Plan the primary payor for parts A and B over Medicare. On the House side, the Ways and Means Committee, in complying with the same Reconciliation instructions, reported out legislation that requires the FEHB Plan to be the primary payor of medical costs for part B of Medicare beginning next January, while making our plan the primary payor of part A of Medicare for persons reaching age 65 on or after that date. If Congress was to adopt either one of these plans, it would have an adverse effect. The results would be premium increases to keep the plans solvent, with the increases being passed onto the contributing members and the Federal government, thus seriously questioning if there are any real savings to the government.

If the proposed change is immediate, it would be necessary for

our Health Benefit Plan to raise its premium anywhere from 14 to 25 percent in order just to continue the current level of coverage through calendar year 1982. This increase would not allow for any increase in benefits, inflationary or administrative costs or mandated changes. To avoid a premium increase, it would be necessary to review all coverage and reduce coverage to make up the losses. Lost coverage, Mr. Chairman, would be an unbearable burden to our retired members and a cruel way of inflating costs. Without a reduction in coverage, our plans would no longer be competitive, and thus could become insolvent.

If these proposals had developed in the traditional legislative process instead of the reconciliation process, we would have been given time to develop accurate data regarding the impact of the changes and potential savings and costs. Instead, you and I are put in the position of developing the facts after legislation is well on the road to acceptance by Congress. No one can really calculate the savings or costs in this atmosphere; a study of the potential impact is badly needed before Congress makes this change permanent law.

In a related matter, the NALC has been a leader with regard to its coordination of benefits and primary and secondary responsibilities. The NALC Health Benefit Plan takes pride in its leadership in guaranteeing our retirees 100 percent of all covered charges so that they have complete comprehensive coverage with no out-of-pocket expenses. This would not be true if the proposed changes are adopted. For example, currently Medicare does not cover the costs of drugs, while our plan pays 100 percent. If the relationship is reversed, our members would have a \$75 deductible to pay, the plan would cover only 80 percent of the drug costs

and Medicare would cover none of the costs. A change in the relationship also would necessitate Congress passing a law requiring standard coordination of benefits, thus raising the administrative costs on the part of the government contract carriers of Medicare by conservatively 60 to 75 percent. Again, this seriously questions the assertion that there is any real saving to the government by reversing the plans.

We feel this is an erosion of benefits promised by law to now make Federal Employees Health Benefit Plans the primary payor. We also believe that the comprehensiveness of the changes has not been studied or perceived - certainly a dangerous move for Congress.

There is one additional issue we would like to address. In 1959, Congress passed Public Law 86-382, in which it legislated the minimum standards for any employees health benefit plan. It let each Union or group negotiate the specifics and special needs of that group of workers. Attempts to require health benefit plans to submit proposed changes to Congress before implementation were defeated as this was not the intent of the 1959 enactment.

However, Congress is now attempting to legislate Federal employee benefits with a proposal to prohibit the use of these benefits to perform an abortion. It is not my purpose today, as Executive Vice President of the NALC, to debate the pros and cons of the abortion issue. It is my purpose to strongly oppose any attempt to limit our ability to negotiate benefits whether it be with OPM or Postal management. As a Union, we will always

resist attempts to restrict our right to bargain on behalf of our membership over mandatory bargaining items proscribed by the National Labor Relations Act of 1935. Let me stress that our right to bargain is the issue at hand - not the issue of abortion. We cannot allow personal feelings to obscure this right.

It is the intent of the NALC Health Benefit Plan to provide the best comprehensive medical coverage for its membership. This coverage is dictated in the form of resolutions from our conventions to negotiate that benefit with our employer, the United States Postal Service. We believe it was not the intent of Congress to dictate the type of benefits to be included or excluded. Any change in this procedure would open the door for Congress to further restrict or cap benefits already negotiated and under contract.

We would like to thank you, Mr. Chairman, and the members of your Subcommittee for giving us the opportunity to testify and present our views. We will be happy to answer any questions you may have.

STATEMENT BY
THE NATIONAL ASSOCIATION OF POSTAL SUPERVISORS
THE NATIONAL ASSOCIATION OF POSTMASTERS

Mr. Chairman, Members of the Subcommittee, my name is Maurice Twomey and I am Executive Vice President of the National Association of Postal Supervisors. With me is Mr. Frank Miklozek, Executive Director of the National Association of Postmasters. Collectively, our organizations represent management employees of the U.S. Postal Service. Joining us is Mr. Andy Ruddock, a consultant on retirement issues to NAPS and a former Director of the Bureau of Retirement, Insurance, and Occupational Health of the Civil Service Commission.

In an effort to be as brief as possible, I would like to highlight our full statement which we have submitted for the record on the issue of making Medicare the secondary insurer under the Federal Employee Health Benefits program. Our organizations all participate in FEHB. The changes pending before you today would have a drastic effect on our membership and the health plans we offer.

The primary objective of making Medicare the secondary insurer appears to be strictly budgetary. However, I would like to point out, Mr. Chairman, that the actual dollar savings to government would be far less than the figure submitted by your colleagues in the Senate Finance Committee.

Under law, employees in the FEHB program pay approximately 40% of the costs while government pays the remaining 60%. This figure may vary, however, depending on the type and size of the plan offered. 40% of the dollar reduction in Medicare outlays would have to be picked up by the employees and 60% by the Federal government as the employer. In the case of the U.S. Postal Service, the amount paid by the USPS is on the average 75% while employees and annuitants pay the remaining 25%.

I almost hesitate to mention the government and Postal Service figures due to what we perceive as a decidedly unfriendly attitude by a majority of your colleagues towards anyone who works for the U.S. government. Despite efforts by legislators such as yourself and your colleagues on this Subcommittee, federal and postal employees have been singled out for some extremely harsh treatment.

If enacted, this proposal would discriminate unfairly against federal and postal employees. Medicare would continue to be the primary insurer when an individual also has coverage under any other insurance plan, including private insurance policies as well as plans sponsored by private industry employers, by unions, or by state and local governments. The sole exception would be federal and postal employees whose health coverage is under an FEHB plan.

Since its inception, Medicare by law has been the primary insurer and has paid the benefits it provides before any other insurance plan is called upon to make payments. In recognition of this concept, all of the plans participating in FEHB have adopted an anti-duplication-of-benefits provision. No individual is paid twice for the same expense

or paid more in benefits than the expenses he or she has incurred.

Every dollar not paid by Medicare would be a dollar that would have to be paid by FEHB. Benefits under FEHB are not paid directly by government, but are paid by the carriers of the plans participating in the program. These plans are experience rated, meaning the premiums paid to each carrier are determined almost entirely by the amounts actually paid out in benefits.

Under this proposal, 40 percent (or 25 percent) of the increase in outlays in FEHB premiums paid to carriers would be offset by an increase in the amounts deducted from the pay of insured employees and the monthly benefits of annuitants. For some plans, it could be as much as 80 to 100%. An increase in FEHB premiums for the sole purpose of reducing Medicare budget outlays would be unfair in the extreme. Private insurance policies and the health insurance plans sponsored by other employers would not be called upon to increase their premiums for this purpose. Again, federal and postal employees would be singled out.

This increase would be tantamount to a pay cut. In light of other proposals pending before this Committee and several other Committees that adversely affect federal and postal employees and their retiree counterparts, such action is unconscionable. We are being asked to do without one COLA while still paying taxes on our retirement benefits. We are being threatened with changes in social security. And, the pay for federal employees is capped far below the point of compar-

ability with private industry. This proposed premium increase for annuitants is a further erosion of the benefits promised by law during the service on which the annuity is based.

The present proposal is not the first time this idea has been considered by the Congress. A provision to effect such a change was enacted as Section 210 of the 1972 Social Security Amendments. The change was to become effective on January 1, 1975, unless before that time, the Civil Service Commission had adopted a series of options under which each plan would directly supplement Medicare. These options would enable each federal and postal retiree would qualified for Hospital Insurance (Part A of Medicare), or who elected to buy Medical Insurance (Part B), or both, to receive the benefit of the maximum government contribution to FEHB and also the general revenue contribution to Part B of Medicare. More than 500 Medicare supplement options would have been required to carry out the provision as enacted in 1972.

Section 4 of Public Law 93-480, enacted October 26, 1974, changed the effective date to January 1, 1976, and required the Chairman of the then Civil Service Commission and the Secretary of Health, Education and Welfare to submit a joint report to Congress by March 1, 1975. This report would outline the steps that would be taken to modify FEHB and carry out the Medicare supplement concept. This report proposed only one option under which FEHB plans would supplement Medicare. This would be paid entirely by government instead of the myriad of options required by Section 210.

This joint proposal was never adopted. Instead, the Congress repealed the provision of the law under which Medicare would become the secondary insurer to FEHB. The repeal was based on a consensus that neither the original proposal for a variety of options nor the joint proposal for a single supplemental option offered any advantage over the coordination method that is still in effect today. The proposed change now before this Subcommittee would create the same Administrative nightmare that Congress rejected after extensive study in 1975.

In summary, Mr. Chairman, we believe this proposal should be rejected for the following reasons:

The net reduction in budget outlays that would result would be only 40% for federal employees and 25% for postal employees of the amount by which Medicare outlays were reduced. Government would pay 60% of the increased FEHB premiums and the Postal Service would pay approximately 75%. The increase in an employee's salary withholdings to meet the increased FEHB premiums would in effect be a pay cut. It would be most unreasonable in light of the myriad of other proposals which penalize federal and postal employees. The increase in the cost of health insurance for retired employees, for the sole purpose of reducing Medicare outlays without a commensurate increase in benefits would be a further unconscionable reduction in the retirement income. Income which was promised by law during the period of service on which the annuity is based. The change would single out federal and postal employees and annuitants for treatment which would be discriminatory,

unreasonable and unfair.

We appreciate this opportunity to express our views on this issue, Mr. Chairman, and want to thank you for your continued efforts on behalf of the federal and postal employees. We would be happy to answer any questions which you may have.



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MONROE W. WILLIAMSON
TREASURER

STATEMENT OF
NATIONAL ASSOCIATION OF RETIRED FEDERAL EMPLOYEES
BEFORE THE
COMMITTEE ON GOVERNMENTAL AFFAIRS
SUBCOMMITTEE ON CIVIL SERVICE, POST OFFICE AND GENERAL SERVICES
U. S. SENATE
ON THE IMPACT OF CURRENT PROPOSALS
ON FEDERAL EMPLOYEES HEALTH BENEFITS PLANS (FEHB)

JUNE 2, 1981

Mr. Chairman, I am Michael C. Nave, President of the National Association of Retired Federal Employees. We have a dues paying membership of 430,000 retired Federal employees, their spouses, and survivors. The Association is 60 years old, and represents the legislative interests of 1.5 million Federal annuitants. We welcome the opportunity to comment on current proposals in the Federal Employees Health Benefits program -- particularly those put forward as a means of achieving savings mandated by the 1982 Budget Resolution.

As this Subcommittee is well aware, our members -- along with our fellow active workers -- comprise those Americans who stand to lose more under the 1982 First Budget Resolution than almost any other single group. Not only do we face major benefit reductions in programs under the jurisdiction of the Governmental Affairs Committee, but we now face relatively greater reductions in programs under the jurisdictions of other Committees of the Congress as well. A conservative estimate of probable cuts affected by the Budget Resolution suggests that Federal employees and retirees will carry approximately 20 percent of all reductions anticipated under the Resolution.

Champion of Retired Federal Employees

Furthermore, under President Reagan's proposed revamping of Social Security benefits, Federal retirees in the future will suffer not only those individual losses to be incurred by all recipients, but will incur additional denials of promised benefits purely on account of their Federal annuities.

Mr. Chairman, we greatly appreciate your efforts and those of your colleagues in attempting to defend Federal retirement and related benefit programs from a meat-ax approach to budget reductions. Retirees from throughout the country look to you, and the Members of this Subcommittee, to insure that any changes in our retirement program be achieved through responsible and thoughtful examination of the issues. While we are not among those groups who would argue for uncontrolled Federal spending, we do not believe that a policy of arbitrary and capricious cuts through the Congressional budget process represents either sound management or responsible legislative action.

Mr. Chairman, during the past few months, I have traveled the country and met with thousands of retirees. The telephones in our Washington offices have not stopped ringing for weeks, while the mail from our membership is as heavy as it has ever been. It is very clear to me that the elderly of this country are living in a state of panic over the implications of the Budget Resolution on their lives and on their financial security. Our Association believes these fears are justified for the assumptions outlined in that Resolution, coupled with President Reagan's proposed ravaging of the Social Security program, promise certain chaos to those whose retirement years have been planned on the integrity of commitments made to them by their Government.

As you consider legislative proposals in federal employees health benefits, I am sure you will bear in mind that 60 percent of all Federal annuities are below the average of \$11,000 a year. The average survivor's annuity is less than \$5,000 a year -- and most Federal retirees do not draw Social Security. This annuity is their primary source of income.

An issue of paramount concern to both active and retired Federal employees is the impact of recent actions by the Senate Finance Committee and the House Ways and Means Committee in approving similar, though not identical, legislation to make Federal Employees Health Benefits plans the primary payors, and Medicare the secondary payor for retirees covered under both programs. The unabashed intent of the legislation is to bail out the Medicare program.

Currently, Medicare is the primary payor for all persons covered under that program. This means that Medicare will cover all health care expenses allowed an individual under the law before any payments are required of the individual's health insurance carrier.

Under the proposal advanced by the Senate Finance Committee, Medicare (both Parts A and B) will become secondary payor, and Federal Employees Health Benefits plans primary payors, for persons covered under both programs. Therefore, the FEHB carrier would be required to pay its benefits first, with any remainder to be covered by Medicare.

The proposal set forth by the House Ways and Means Committee is slightly different, although in principle it is identical to the Finance Committee plan. The Ways and Means Committee would make Medicare Part B secondary for all present and future Federal retirees as of January 1982. Furthermore, it would make Medicare Part A secondary for all new Federal retirees coming onto the Medicare rolls after January 1982.

The principal impact of this proposal would be to shift the primary financial burden of retiree health claims onto the backs of FEHB insurance carriers and away from the Medicare program. Since Medicare is the primary carrier for all persons on its rolls, Federal employees and retirees would be the only group to be arbitrarily singled out for this special treatment.

These proposals very clearly spell disaster and distress for thousands of Federal retirees, whose fixed incomes are already under the budget axe in as many as a half-dozen committees of Congress. Furthermore, it will mean massive premium increases for millions of active Federal workers and their families who are already under a budget squeeze due to unreasonable limitations on pay raises.

The justification for this proposal is elusive.

Medicare Part A can only be acquired by an individual who earns such coverage by participation in Social Security through contributions made in covered employment, or through such participation by his or her spouse.

Medicare Part B is optional for all retirees and must be purchased separately. The only way a Federal retiree may qualify for either Part A or Part B is through the normal criteria established by Congress for participation in Medicare. The Federal retiree is not entitled to any special benefit or "windfall" on account of his employment in a non-covered retirement system. To qualify for benefits under Medicare, a Federal retiree must pay -- just like everyone else.

Our organization opposes this legislation without qualification. There can be no reasonable explanation for this discriminatory legislation except that it neatly saves money in the Medicare program without any adverse effect on the vast majority of Medicare recipients. It is yet another example of holding down Federal spending at the expense of the Federal worker and retiree.

The effect of these proposals on individuals is obvious -- higher health care premiums for the worker and retiree without any upgrading of the quality of benefits. According to some FEHB carriers, the proposals advanced by Finance and Ways and Means could raise these premiums in some cases by as much as 150 percent. This is an outrage. The very idea of turning to retired persons on fixed incomes and their fellow active

workers to bear the burden of Congress' failure to create a sound Social Security program is inexcusable. Many of these retirees are simply incapable of carrying this additional burden. Some will be forced to drop their FEHB insurance and take a chance on the adequacy of Medicare as their sole protection against spiralling medical costs.

Mr. Chairman, our organization urges this Subcommittee to look closely at the savings anticipated by the Finance Committee and the Ways and Means Committee as a result of passage of this legislation. Many of the figures used by these Committees have turned out to be little more than estimates of staff people totally unfamiliar with the Federal Employees Health Benefits program. Often overlooked in the Committees' discussions of this issue is the fact that the Federal Government picks up 60 percent of the health premiums under FEHB. Depending on the premium increases resulting from this proposal, the Federal Government could actually end up paying out more than it presently does for the health insurance of its workers. Furthermore, the administrative complexity to be imposed on the Social Security Administration and hospital administrators, who must figure out who is entitled to what benefits from which carrier, promises to be a costly nightmare.

Mr. Chairman, you are to be commended for holding hearings on this legislation even though your Subcommittee does not have direct jurisdiction over Medicare. These are the first hearings which have been held in the Senate on this legislation, while the Post Office and Civil Service Committee is the only committee in the House to have held hearings on this. The fact that the Committees with direct responsibility for this calamity have chosen to avoid public criticism of their proposal is indicative of the blind, arbitrary nature of the budget reductions Congress is now considering. We hope that you and the Members of this Subcommittee will stand firm in your commitment to insure that any changes in the FEHB program be made in a thoughtful and judicious manner. .

Our Association strongly urges you to use all the influence in your power to dissuade your Senate colleagues from this invitation to disaster. Those who argue that legislation like this is necessary to control Federal spending are as naive as they are foolish. Only the narrow path of political expediency justifies the existence of these proposals. It is time to call a halt to the irrational and irresponsible attacks on the Federal workforce and once again restore a sane voice of reason to the personnel policies of the United States Government.

Thank you, Mr. Chairman, and Members of the Subcommittee.

NATIONAL
FEDERATION
OF FEDERAL
EMPLOYEES

NFFE

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SERVING FEDERAL EMPLOYEES AND THE NATION SINCE 1917

STATEMENT BY
THE NATIONAL FEDERATION OF FEDERAL EMPLOYEES
BEFORE
THE SUBCOMMITTEE ON POST OFFICE, CIVIL SERVICE, AND GENERAL SERVICES
SENATE COMMITTEE ON GOVERNMENTAL AFFAIRS
ON
THE FEDERAL EMPLOYEE HEALTH BENEFITS PROGRAM
June 2, 1981

Mr. Chairman and Subcommittee Members: My name is James Peirce and I am president of the National Federation of Federal Employees. I appreciate this opportunity to present NFFE's views regarding the relationship of Medicare to the Federal Employee Health Benefits Program (FEHBP). It is a subject of deep concern to our membership, as well as to all Federal workers and retirees.

Since it was established in 1959 by the Federal Employees Health Benefit Act (Public Law 86-382), the FEHBP has been considered a unique, and very successful, system of health care coverage for an extremely large number of subscribers, now numbering nearly 10.5 million people. In fact, it has been frequently mentioned as a model for national health insurance. The FEHBP is one of the most effective of the few benefit programs enjoyed by civil servants. While our organization does have several problems with it, by and large we are pleased with its overall design and operation.

Not surprisingly, however, health insurance for Federal employees, like virtually every other area of civil service compensation, has been attacked by the present Congress. In the wanton rush to reduce government spending an issue has gained momentum which could have disastrous implications for the FEHBP.

I am speaking, of course, of the measures recently approved by the House Ways and Means Committee and the Senate Finance Committee which would fundamentally alter the relationship between the Medicare program and the FEHBP. The House proposal would make the FEHBP the primary insurer for the Medicare outpatient program, Part B, for all Federal retirees beginning January 1, 1982. Furthermore, the FEHBP becomes the primary insurer for the Medicare hospitalization plan, Part A, for all Federal retirees who enroll in Medicare, Part A on or after January 1, 1982. The Senate provision is much harsher, making the Federal health insurance program the primary insurer for all eligible civil service retirees with Medicare coverage.

Current law, as you know, provides essentially the reverse of this relationship; the FEHBP is the secondary insurer to Medicare.

NFFE strongly objects to these proposals, which are really nothing more than a cut in earned benefits for a certain group of individuals; no other work-related group health insurance plan would be affected. In addition to this obvious discriminatory aspect, the measures would have a serious, negative impact on the FEHBP and would place an undeserved financial burden on civil servants. This is especially disheartening in light of the nominal savings that would result from the proposed changes.

The House Ways and Means Committee has tentatively estimated that the savings in fiscal year 1982 would be \$60 million for the Part B proposal and \$11 million for the Part A provision -- an insignificant amount when you consider the consequences for Federal employees and their health insurance program. The Senate provision, while transferring nearly \$1 billion in costs from Medicare to the FEHBP, would only save approximately \$350 million. It should be noted, however, that virtually all of the savings from these measures would be borne by Federal workers and annuitants.

It is unfair that Federal workers should be forced to subsidize the Medicare program twice. Like all citizens, they now support Medicare with their tax dollars (23 percent of the program's income is from general revenues) and, for those eligible for Part A, with payroll contributions. The proposals now under consideration, however, would shift some of the costs of the Medicare program to the FEHBP, and therefore increase premiums. Since approximately 40 percent of premiums are paid by Federal employees, a substantial part of this added cost would be placed on their shoulders. Again, this is patently unfair.

Aside from the direct impact on employee compensation, the proposals would be highly disruptive to FEHBP plans, especially those with large numbers of retirees among their subscribers. The added cost to these plans for benefits previously funded by Medicare could increase premiums substantially. In order to keep premiums at a competitive level, either other benefits would have to be eliminated, or a separate program for retirees, at exorbitant rates, would have to be established. Both of these options would undermine the essential aims of the FEHBP, and may in fact signal the end of the program as we know it today.

To reiterate, the proposals to make to the Federal Employee Health Benefits Program the primary insurer for Medicare are inequitable and potentially disastrous. NFFE urges this subcommittee to do everything in its power to defeat them.

That concludes my statement. I will be happy to answer any questions.

STATEMENT OF

EUGENE B. DALTON, PRESIDENT

NATIONAL LEAGUE OF POSTMASTERS

BEFORE THE

SUBCOMMITTEE ON CIVIL SERVICE, POST OFFICE
AND GENERAL SERVICES

COMMITTEE ON GOVERNMENTAL AFFAIRS

UNITED STATES SENATE

JUNE 2, 1981

Mr. Chairman and Members of the Committee:

My name is Eugene B. Dalton. I am President of the National League of Postmasters (NLPM), an association representing Postmasters throughout the United States and Puerto Rico.

This Association offers a health plan to our members under the Federal Employees' Health Benefits Program (FEHBP). The current enrollment in our plan, the Postmasters Benefit Plan (PBP), is approximately 80,000. This enrollment is comprised of roughly 73,000 employees and 7,000 annuitants. The current NLPM Postmasters Benefit Plan is a negotiated plan between the NLPM and the U.S. Office of Personnel Management.

I appreciate the opportunity to present, for the record, our concerns in regard to a proposal currently being considered by the Senate Finance Committee. This proposal is being considered as a part of the budget reconciliation program, and would require insurers under the FEHBP to be the primary payor for both active and retired federal employees over age 64, who are also covered by Medicare.

Under present law, an individual who is covered under both Medicare and FEHBP has most of his medical costs paid for by Medicare, with his FEHBP health insurance plan paying benefits only to the extent Medicare has not paid them.

This relationship would be reversed under the Finance Committee proposal, with the Federal Employees' Health Benefits Program being primary payor and Medicare being secondary payor. This change in roles will have a drastic impact on Federal health benefit plans.

If enacted, this proposal would discriminate unfairly against federal and postal employees. Medicare would continue to be the primary insurer when an individual also has coverage under any other insurance plan, including private insurance policies as well as plans sponsored by private industry employers, by unions, or by state and local governments. The sole exception would be federal and postal employees whose health coverage is under an FEHBP.

As you know, the House Ways and Means Committee is considering a somewhat more modest proposal, which would make Medicare Part B primary for all dual beneficiaries, and Medicare Part A would be primary only for new retirees.

In both proposals, the Committees assume that the costs associated with shifting primary coverage to FEHBP would be assumed by the same combination of government and employee paid premiums. What these proposals fail to consider is that the carriers of the FEHBP plans will be forced to raise their premiums, for active employees and retirees, to compensate for the increased coverage.

According to OPM Director Devine, the Federal health benefit plans will be forced to increase their premiums some 21% to cover the increased expense of providing primary coverage for those eligible for Medicare, with some particular plans with heavy concentrations of retirees increasing premiums by more than 70%. The NLPM Postmasters Benefit Plan is one of the plans that will be subject to the larger increase in premiums. We have estimated that the cost for providing primary coverage on Medicare participants would increase \$1,000.00 per year, per individual enrolled in Medicare.

This would cause a sharp increase in premiums, and its uneven distribution could lead to two results. First, many of the individuals with Medicare eligibility might drop out of FEHBP altogether, so they could once again receive their health care benefits from Medicare. The second result we would foresee is that employees and annuitants in the FEHBP may start changing plans, in an effort to avoid the high premiums in the plans where the remaining Medicare eligibles are enrolled.

In reviewing what administrative actions could be taken in order to keep the FEHBP operating if one of these proposals does in fact become law, one option we would have to consider very seriously would be to delay or cancel completely the open season this year, thus delaying or

preventing enrollees from changing plans. On the other hand, it would also force employees and annuitants to either remain in the plan they are in now and be subjected to the drastic premium increases foreseen, or drop out of the FEHBP altogether.

In addition to the possibility of having to cancel the open season for this year, it would also place a severe hardship on all of the federal plans to propose new premium increases. Under present regulations, each federal plan must have their premium proposals in by the end of July. If this legislation were enacted into law this year, it would be impossible for sufficient time to be given to the plans to do a feasibility study on what premium rate increases would be needed in order to keep the individual plans solvent.

Mr. Chairman, our Association urges this Subcommittee to look closely at the savings anticipated by the Finance Committee and the Ways and Means Committee as a result of passage of this legislation. Many of the figures used by these Committees have been calculated by Committee staff who are totally unfamiliar with the FEHBP.

Had these proposals been developed in the traditional legislative process, instead of the budget reconciliation process, we would have been given time to develop accurate data regarding the impact of the changes and potential

savings and costs. Instead, we are put in a position of developing the facts and data after legislation is well on the way to acceptance by Congress. A study of the potential impact is badly needed before we can assume what actual savings and costs will be incurred, if Congress does in fact put one or both of these proposals into law.

Further, we believe that the proposals adopted by the Senate Finance Committee and the House Ways and Means Committee grossly overestimate the savings to the Federal Government. Often overlooked in the Committees' discussions of this issue is the fact that the Federal Government picks up 60% of the health premiums under FEHBP. Depending on the premium increases resulting from these proposals, the Federal Government could actually end up paying out more than it presently does for the health insurance of its workers.

Mr. Chairman, it has always been the intent of the Postmasters Benefit Plan to provide the best comprehensive medical coverage for its membership at a reasonable cost. However, if either of the proposals before Congress are enacted, the net effect will be higher health care premiums for workers and retirees with doubtful upgrading of the quality of benefits.

Mr. Chairman, we strongly urge you to stand firm in your commitment to insure that any changes in the FEHBP be made in a thoughtful and judicious manner.

I thank you for the opportunity to present our views on these proposals. I will be happy to answer any questions you may have.

STATEMENT OF
DEAN KING, PRESIDENT
NATIONAL RURAL LETTER CARRIERS' ASSOCIATION

BEFORE THE
SUBCOMMITTEE ON CIVIL SERVICE, POST OFFICE AND GENERAL SERVICES
SENATE COMMITTEE ON GOVERNMENTAL AFFAIRS
UNITED STATES SENATE

JUNE 2, 1981

Mr. Chairman and Members of the Committee:

My name is Dean King. I am President of the National Rural Letter Carriers' Association, an organization representing the rural letter carrier craft employees of the United States Postal Service.

We currently have a membership of 62,664 comprised of 30,079 regular employees, 15,157 substitute employees, and 17,428 annuitants.

This Association offers a health plan to our members under the Federal-Employee's Health Benefits Program. The current enrollment in our plan, the Rural Carrier Benefit Plan, is 41,215. This enrollment is comprised of 22,691 employees and 18,524 annuitants.

Mr. Chairman, Members of the Committee, we are greatly concerned with the proposal pending before the Subcommittee which would cause the health plans under FEHBP to assume primary carrier liability in those double coverage enrollments involving Medicare.

This is an ill-advised proposal which would have a very adverse impact on federal employees and annuitants covered under FEHBP. The immediate impact will be a sharp increase in premium costs which will severely affect employees, annuitants, and the employing agencies. Although we have not had sufficient time to

do a statistical analysis of the premium adjustment which would be required, it seems virtually certain that it would require a premium increase of approximately 40% to 50%. This, plus the increase in a premium required because of inflation, would mean an actual increase of premiums in the next contract approximating 55% to 65%. We deem that this would be an unconscionable action.

For employees, the exorbitant increase in premium rates would be both unfair and discriminatory. It is unfair due to the fact that premiums are determined based on the experience of the group which includes both employees and annuitants. A large number of the 18,524 annuitants enrolled in the Rural Carrier Benefit Plan are also covered under Medicare. The federal health program is probably the only program in the nation which sets premium rates by considering employees and individuals covered under Medicare as a group. The fact that Medicare assumes first liability on expense incurred by those enrolled makes it feasible to experience rate plans on a group basis. If FEHBP assumes primary carrier liability, the cost of all federal health plans will, on the average, greatly exceed costs for similar programs provided by states, other governmental units and private industry. This would be gross discrimination in that it would cause the premium costs for plans insuring federal employees and annuitants to greatly exceed the cost of similar group plans provided employees and retired individuals enrolled in other group health insurance plans.

We deem this to be a very serious problem. It would result

in a situation which would give rise to very severe criticism of the United States Government and of the Congress for providing a program for federal and postal employees, and annuitants, which would be costing a great deal more than similar plans offered to other United States citizens in the group plans in which they are enrolled. Despite the fact that the cost differential could be explained, by noting that the federal health program assumed prime carrier liability for individuals also covered under Medicare, this fact would be glossed over by the media and the press. Federal employees and annuitants would be again subjected to unfair criticism by indicating that they were enjoying a "bonanza" in the protection provided by their health plans. The point which would be highlighted would merely be the fact that the federal plans cost considerably more than other similar group plans.

The proposal would also be discriminatory in that the higher costs mandated upon the federal health plans would cause those employees and annuitants to personally assume a much higher premium cost for their coverage than costs which would be reflected in other health plans.

This is an ill-conceived proposal and we feel certain that any in-depth analysis will clearly disclose that the mandating of primary carrier liability on the federal health plans is a totally unwarranted proposal. It is highly questionable that it would ultimately result in any cost savings. The short-term impact would

be to reduce the costs of the Medicare program under Social Security, but it is merely a "rob Peter to pay Paul" move. In fact, we seriously believe that the resulting cost increases in the federal programs will probably outweigh any cost savings which would be reflected in the Medicare program.

It should also be noted that the major impact of health care costs are the result of the higher utilization of benefits by those 65 and older (those generally covered under Medicare). In the federal health benefits program, the expenses for this group run $2\frac{1}{2}$ to 3 times as high as the expense incurred by those insured under age 65. The simple, logical cause for this is the fact that health care utilization is much greater as individuals grow older.

The proposal would not only hurt the annuitants with the sharply increased premium costs for their enrollment in FEHBP, but it would also lessen the health insurance protection they presently enjoy if covered under Medicare and currently enrolled in a federal plan which follows the coordination of benefits guidelines providing "aggregate coordination" of benefits. Throughout the insurance industry "aggregate coordination" is a type of coordination of benefits, when an individual is covered under two group plans, which causes the carrier accepting secondary liability to consider as a covered benefit all expense covered under the benefit provisions of either plan. The plan sponsored by this organization, the Rural Carrier Benefit Plan, does use COB guidelines of "aggregate coordination" and any savings incurred due to double coverage is used to

allow benefits for all expense covered under either the Rural Plan or Medicare. Another loss of benefit protection for individuals covered under Medicare would be the loss of the benefit provisions in our plan, and in many other federal plans, which provides for the waiving of any deductibles and coinsurance. If the federal plans assume primary carrier liability, they will apply the deductible and coinsurance features of the plan and under the present provisions of Medicare, the deductibles would also be applied under that program. The net result is that annuitants would suffer by needing to pay the higher premium rates and they would receive less health insurance protection which, in simple language, means that they will also be paying a higher portion of their health insurance expense. It would appear to be a very difficult matter to try to explain to our annuitants why they would need to pay higher health premiums costs and receive less benefits.

In summary, we deem this proposal to be totally unworkable. If it is enacted into law, there is no question but that corrective legislation will have to be considered in the immediate future to correct the problems which would be created.

Mr. Chairman and Members of the Committee, we earnestly urge that you disapprove this ill-conceived proposal to transfer primary carrier liability from Medicare to the Federal Employees Health Benefits Program. We urge that the proposal not be approved.

Respectfully submitted,

Dean King,
President

Statement of

Jerry D. Klepner
Director of Legislation
National Treasury Employees
Union

to the

Subcommittee on Civil Service and General Services
of the
Committee on Governmental Affairs
U.S. Senate
Hon. Ted Stevens
Chairman

Oversight Hearings on Federal Employees
Health Benefits Program

Washington, D.C.

June 2, 1981

I am Jerry D. Klepner, Director of Legislation for the National Treasury Employees Union. Our union is the exclusive representative of over 120,000 employees in numerous Federal agencies.

We commend the Subcommittee for holding these very timely oversight hearings on the Federal Employees Health Benefit Program (FEHBP). We say timely because at present the program is faced with a major problem which threatens to undermine the health insurance coverage available to Federal workers. Specifically, we are concerned about the efforts of some in Congress to transfer the primary health care coverage of Federal retirees from Medicare to the FEHBP.

Measures which would bring about this change beginning in Fiscal Year 1982 have already been passed by the House Ways and Means Committee and the Senate Finance Committee. We urge this Subcommittee to do all in its power to maintain the status quo and ensure that the level of health insurance protection available to Federal retirees remains consistent.

Under the present system, Medicare is considered the primary payer of benefits to a civil service annuitant who qualifies for such coverage; the individual's FEHBP plan serves a supplementary role. The House and Senate Committees would both reverse the process so that an FEHBP program would be the payer of first resort with Medicare paying only those bills which are not covered by the annuitant's Federal plan. The Senate Finance Committee passed a measure which would make the FEHBP the primary health insurer of Federal retirees in place

of all Medicare coverage. The Finance Committee's provision becomes effective October 1, 1981, and applies to those currently on the retirement rolls as well as future annuitants. The panel estimates that a net savings of \$390 million would be realized from the enactment of this proposal.

The Health Subcommittee of the House Ways and Means Committee adopted a two part proposal affecting the FEHBP. The first portion addresses Part B Medicare coverage, which is optional and which may be purchased by any worker regardless of whether he/she has contributed to the Social Security System. Under this amendment, which the Subcommittee estimated will save \$11 million, FEHBP would supercede Part B Medicare coverage as the primary payer for Federal retirees beginning January 1, 1982.

The second provision adopted by the Subcommittee designates FEHBP as the primary payer over Part A of Medicare, which is the type of coverage automatically provided to any employee who is eligible for benefits under the Social Security System. The measure is prospective, affecting only those who retire on or after January 1, 1982. The estimated savings that would result from this proposal are \$60 million. Both of these measures have been passed by the full Ways and Means Committee.

We strongly question the savings figures that have been cited by the Finance and Ways and Means Committees. The provisions that have been adopted would contain numerous hidden costs for both Medicare and the FEHBP and would have severe long range effects on both systems.

The Committees assume that the costs associated with shifting primary coverage to FEHBP would be assumed by the same combination of government and employee paid premiums. What these proposals fail to consider is that the carriers of the FEHBP plans will be forced to raise their premiums - for active employees and retirees - to compensate for the increased coverage. Since the government pays an average of 60 percent of premiums under the FEHBP, substantial costs would be incurred by that program. While there may be immediate short term savings by having FEHBP responsible for primary coverage, we believe that the long range premium increases that will be necessary to meet this obligation could prove to be even more expensive.

Similarly, Medicare would also experience hidden operating expenses if this proposal were adopted. Though Medicare would no longer be the payer of first resort for many individuals, the program would be forced to change its operating procedures in order to implement and enforce the Committee measures. For example, many of the forms which retirees now submit to providers of health care would require revision.

Furthermore, it would be administratively difficult, if not impossible, for the Social Security Administration and the Medicare intermediaries to determine which retirees are also covered by FEHBP. The cost of enforcing this provision could prove to be considerable. We question whether the Committees considered such increased expenses in endorsing these provisions.

The Committees' actions would also throw the present health benefit program into immediate chaos. Negotiations between the government and the carriers to determine the benefit and premium structure for the 1982 plans are already well underway. If this provision became effective on October 1, 1981, as the Senate is proposing, the parties would be forced to reopen negotiations, revise their plans to accommodate these increased costs, print brochures, and distribute this information to employees in time for the November 1981 open season. This would be a virtually impossible task.

Implementation of this proposal in FY 1982 would also have an adverse effect on many retirees. Because they rely on the Medicare benefits earned during their years in the private sector, many retirees purchase only minimal coverage under the FEHBP. These individuals would be forced to substantially increase their health insurance coverage at a considerable cost and they would not be entitled to backup Medicare Part A coverage. Those who earned Medicare benefits would receive little or nothing for their investment while still being forced to pay higher FEHBP premiums.

The effect that this provision would have upon retirees can be illustrated through our union's health insurance plan within the FEHBP. Our program, which is underwritten by the Prudential Insurance Company, has approximately 12,000 subscribers, 6 percent of whom are retired. Of the annuitants who participate in our plan, only 40 percent, or 228 individuals, are also eligible for Medicare.

Prudential estimates that if the Senate Finance Committee's proposal becomes law, the premiums for our health plan will be increased 10 percent. Even though less than 2 percent of our plan's total enrollment would be directly affected by the Committee's recommendation, every subscriber - as well as the government - would be forced to bear substantially higher premium rates.

Proponents of the Committee measures have disputed our contention that they will raise costs. They claim that the increase in premiums in FEHBP plans will be offset by the number of individuals who would cancel their coverage under the program since those individuals without coverage would be entitled to Medicare benefits. The dropout rate, they argue, will ease the strain on the health plans by reducing the number of claims received by the carriers.

This reasoning, however, does not reflect the manner in which the insurance companies anticipate a major change in the program such as that proposed by the Committees. Normal industry practice dictates that the carriers will anticipate little or no change in enrollment. In this way, the companies guarantee that their projected costs are not exceeded by their actual expenses. The adjustment for the initial year that the Committee proposal is in effect will reflect virtually no cost savings to either FEHBP subscribers or the government based upon reduced participation.

We also believe that estimates of the dropout rate in the FEHBP may be greatly overrated. If either the Finance or the Ways and Means Committee proposals are adopted and FEHBP premiums increase, retirees may have no choice but to pay the higher rates. We remind the Subcommittee that senior citizens have great difficulty in purchasing health insurance at reasonable prices

and that many policies do not cover pre-existing conditions, leaving many retirees without necessary coverage. Even if FEHBP premiums rise substantially, there is no reason to believe that retirees will be able to purchase adequate individual insurance policies, forcing them to continue in the Federal program.

Before closing, we also ask the Subcommittee to consider the effects of the Committee provisions in the context of other changes in Federal compensation that have been enacted or are being contemplated. Already this year, the Reagan Administration has sought - and the Committee on Governmental Affairs has endorsed - a reduction in the number of cost-of-living adjustments received by civil service annuitants and a pay raise of only 4.8 percent for active employees. In addition, proposals are being examined which would reduce the amount of social security benefits received by some Federal retirees, and reduction-in-force notices are now being circulated in several agencies.

We call upon this Subcommittee to consider the cumulative effect of all of these proposals. Already, the morale of the Federal work force is badly shaken and scores of dedicated employees have left the Federal government for more lucrative and rewarding jobs in private industry. Giving serious consideration to any provision which will disrupt the FEHBP will only add more fuel to an already raging fire. We believe that Federal employees deserve better than to have their pay and benefits eroded so thoroughly and so suddenly.

In short, we believe that the proposals adopted by the Senate Finance Committee and the House Ways and Means Committee greatly overestimate the savings to the government. Though different in

scope and effective date, both measures would unfairly penalize present and future retirees by placing an additional burden on the FEHBP and they would drive premium costs considerably upward. We hope that the severe problems with these proposals will be recognized and that they will be rejected by the full House and Senate.

We thank the Subcommittee for allowing us to express our views on the problems now facing the FEHBP. If there are any questions, we will be pleased to respond to them.

Senior Executives Association



Statement of
G. JERRY SHAW
President
SENIOR EXECUTIVES ASSOCIATION

Before the

SUBCOMMITTEE ON CIVIL SERVICE AND GENERAL SERVICES

COMMITTEE ON GOVERNMENTAL AFFAIRS

JUNE 2, 1981

Mr. Chairman, my name is G. Jerry Shaw and I am president of the Senior Executives Association. The Association is a professional organization representing the interests of senior executives and super-grade employees throughout the government.

I appreciate the opportunity of being able to appear before this subcommittee to express our concerns over what we perceive to be a most significant and perhaps an unconstitutional act on the part of Congress in dealing with federal employees. I am speaking specifically about the proposed legislative changes concerning the primary/secondary role of the Federal Employees Health Benefits Program in relationship Medicare.

Under the current health-care system for federal retirees, Medicare is designated as the primary insurer of medical costs, for those covered, while FEHB plays a secondary role. The proposed legislation would switch the primary responsibilities to the FEHB program, leaving Medicare to play a minor supplementary part in health care coverage. This in turn shifts the burden of health care cost from the federal government to the federal employee. Although the House and Senate versions of this proposed legislation differ significantly, the underlying concept of both versions is clearly a violation of the rights of all federal employees.

It is obvious that this Budget Resolution Proposal is an attempt to shore up the Medicare program. But, in reality, such a proposal is really just a transactional tradeoff, for the government as well as the federal employee, will be forced to make larger monetary contributions to the FEHB program. The manipulation

of the Federal Employees Health Benefits Program is not the way to solve the Medicare Program. It must be kept in mind that federal employees have already contributed significantly to the funding of their FEHB program. This is not like most plans in the private sector where the employer pays for the entire plan. Here the employees are paying their own freight. They are not paying for someone else to ride on the train.

You have heard much testimony on this subject. Some of the points that have been made are worthy of reiteration.

- The proposal is inequitable. The proposal, if adopted, must result in significantly higher premiums. This will put even more of a financial burden on both federal employees and retirees-- a burden our counterparts in private industry are exempted from.

- The intent of Congress has always been to regard Medicare as an Entitlement Program. Under the current proposals, Medicare would remain an entitlement program for most Americans, but not for Medicare --eligible employees of the Federal Government and their Medicare-eligible dependents.

- All federal employees would have to pay significantly higher premium rates--not just retirees.

- If either of these proposals are adopted, the increased cost will not only accrue to the employees, but to the employer as well. Premiums must increase to keep the plans solvent. What is the point of having the Government decrease its cost to Medicare but increase its cost for the Federal Employees Health Benefit Programs?

- It is unfair that federal workers should be forced to subsidize the Medicare program twice. Like all other citizens, part of their tax dollar goes to fund Medicare. The current proposal, by shifting Medicare primary responsibilities to FEHB, would increase premiums. The net result being federal employees would be paying twice.

Mr. Chairman, I, as a representative of the approximately 7,000 senior executives who have the responsibility of providing the leadership and motivation for the federal work force state categorically that these types of actions by the Congress will only continue to infuriate those who make this country run. Congress must stop trying to treat federal employees like second class citizens.

In addition, Mr. Chairman, we have grave doubts about the ability of either the House or the Senate proposals to pass constitutional muster. We understand that AFGE feels as we do that the proposals contain constitutional infirmities.

The equal protection of the laws and due process provisions of the Constitution guarantee that citizens will be treated equally and fairly when being subjected to government action. Both the granting and denial of benefits must fall with equal weight on the shoulders of those citizens the law affects. There is room for separate classifications in the various laws Congress passes, but the distinctions must not be arbitrary or capricious nor may they unfairly discriminate among the classes of citizens affected.

Our preliminary study of the proposals indicates to us that the law would place an unfair burden on government employees and retirees. They alone would be prevented from obtaining Medicare coverage on the same basis as all other citizens, even though they met all the identical qualification standards presently imposed by the law. Instead, so long as they had coverage under the FEHB program, they would derive little, if any, benefit from Medicare. If the difference ended there and there was no cost effect, then the statute would not be objectionable. But it does not. Instead, government employees and retirees would have to pay up to 100% more in additional premiums not required of any other class of citizens in order to have their insurance program pick up the costs borne by Medicare for every other citizen covered by Medicare. This would, in effect, subsidize the Medicare program for all other participants. We do not see how this burden which falls only on government workers and retirees, can be considered fair or equitable, nor do we see how it can be constitutional.

We request that this Subcommittee seek to have Congress and the Administration give careful consideration to this constitutional infirmity and stop the consideration of these proposals.

Thank you for this opportunity to testify. I would be happy to answer any questions you might have.

♦ ♦ ♦ ♦



151 Farmington Avenue
Hartford, Connecticut 06156

Laurence B. Huston, Jr.
Assistant Vice President
Group Division

JUL 1 1981

June 26, 1981

The Honorable Ted Stevens
Chairman, Subcommittee on Civil Service,
Post Office, and General Services
Committee on Governmental Affairs
Washington, D.C. 20510

Dear Senator Stevens:

In response to your letter of June 8, 1981, attached are the answers to the questions raised.

We appreciate your interest and that of your Subcommittee on this important matter and we stand ready to furnish any other information which you may require.

Thank you for giving us an opportunity to submit written testimony and to respond to your questions.

With best wishes,

Sincerely,

Laurence B. Huston, Jr.
Laurence B. Huston, Jr.
Assistant Vice President
Group Division

cb
attachment

ETNA LIFE & CASUALTY'S RESPONSE TO QUESTIONS
ON THE PROPOSED FEDERAL HEALTH BENEFIT PLAN HEARING RECORD

1. What percentage of federal employees and retirees participate in your plans?

13% of federal employees and retirees who are enrolled under the Federal Employees Health Benefits Program are enrolled under either the High Option or Low Option of the Government-Wide Indemnity Benefit Plan administered by Etna Life Insurance Company

2. In which of the options are retirees most concentrated?

As of April 1981, there were 175,792 annuitants and survivors covered under the GWIBP High Option, which represents 52% of the 337,032 enrollees under that option. There were 70,981 annuitants and survivors covered under the Low Option, which represents 62% of the 115,227 enrollees covered under that option.

3. What will be the impact on your premium structure if the Finance Committee proposal is adopted?

Because GWIBP covers a large number of Medicare eligibles, adoption of the Finance Committee proposal making Medicare secondary to FEHB would increase our claim liability significantly. To make premium rates self-supporting, significant increases would be needed, as shown in the following table.

GOVERNMENT-WIDE INDEMNITY BENEFIT PLAN
ESTIMATED IMPACT OF MAKING MEDICARE SECONDARY TO GWIBP

	<u>Enrollment*</u>	<u>Bi-Weekly Rates-Combined</u> <u>Government and Enrollee Contribution</u>		<u>Percent Increase</u>
		<u>1981</u>	<u>1982 (est.)**</u>	
<u>High Option</u>				
Self	120,561	\$25.38	\$43.83	+ 73%
Self & Family	<u>221,336</u>	<u>50.75</u>	<u>71.81</u>	<u>+ 41</u>
Total	341,897	\$41.80	\$61.94	+ 48%
<u>Low Option</u>				
Self	46,874	\$12.79	\$38.82	+204%
Self & Family	<u>69,101</u>	<u>30.24</u>	<u>62.82</u>	<u>+108</u>
Total	115,975	\$23.19	\$53.12	+129%

* as of 3/81

** includes estimated inflation factor of 16%

4. Would retirees find it less expensive to opt out of the federal plans, be primarily covered under Medicare and take out supplemental coverage under a private sector plan than if they remained in the system, assuming the adoption of the proposed changes?

We would expect that many retirees will find that the increased contribution requirements resulting from the Finance Committee's proposal are so significant that they will opt out of the federal program. Some of those who opt out will elect supplemental coverage under a private sector plan, when such can be obtained at lower cost than their contribution requirement, while others may elect to go bare, i.e., rely totally on Medicare for their health care financing. It is difficult at this time to quantify and qualify this statement because we have no basis for pre-determining enrollee actions in this regard. Nevertheless, it can be stated that there will be no savings to the Medicare program with respect to any enrollee who elects either of these alternatives.

5. How does the Finance Committee proposal affect your current negotiations with OPM?

Our forthcoming negotiations with respect to 1982 premium rate requirements are totally impacted by the uncertainties surrounding the Finance Committee's proposal. We must make our 1982 premium rate proposal to OPM by July 31, 1981. If legislation affecting the primacy of Medicare versus the Federal Employees Health Benefits Program is still pending at that time, then our 1982 premium rate proposals will be contingent upon no change in the present primacy arrangements.

6. Do you foresee the possibility where you may withdraw your health plans or drastically change the coverage as a result of the effect of the Finance Committee's proposal?

We do not, at this time, foresee the possibility that we would seek to withdraw the Government-Wide Indemnity Benefit Plan as an option for federal employees. Nor do we anticipate a drastic change in the coverage we provide if the Finance Committee's proposal produces specific legislation and if that legislation is enacted and signed into law. This is not to say that we are unconcerned about the future, because we are concerned. We have been pleased to administer the Government-Wide Indemnity Benefit Plan since the inception of the Federal Employees Health Benefits Program and we would hope that we can continue to have the privilege of administering that program for many, many years to come.

7. Where will the administrative burdens fall, assuming the adoption of this proposal?

The most identifiable, and presumably quantifiable, administrative burdens of compliance with the Senate Finance Committee's proposal

will fall on Medicare carriers and intermediaries. This is so because the Medicare program has not been structured to consider other coverage in determining benefits payable under either Part A or Part B.

We would assume that in order to assist Medicare carriers and intermediaries to coordinate Medicare benefits with those payable under the federal program, either the legislation itself or regulation attendant thereto would impose new administrative requirements that the Federal Employees Health Benefits Plans provide information relative to their plans' benefit payments to Medicare carriers and intermediaries.

These combined administrative requirements which become administrative costs are not quantifiable at this time, but will reduce any savings to the federal government which might otherwise result from implementation of the Finance Committee's proposal.

**Blue Cross
and
Blue Shield**
Associations



Federal Employee Program
1800 M Street, N.W.
Washington, D.C. 20036
202/785-7950

June 16, 1981

Congressman Ted Stevens
United States Senate
Washington, D. C. 20510

Dear Mr. Stevens:

In response to your letter of June 8, 1981, I am enclosing our reply to the questions you presented. I hope that our responses to these questions and our prepared statement of June 2, 1981 will assist the Committee as it completes its work on this important issue.

The integrity and stability of two vitally important programs, Medicare and the Federal Employees Health Benefit Program (FEHBP) are subject to an uncertain future if the Finance Committee proposal is not thoroughly analyzed in the light of the several significant issues which have been raised in hearings, in written statements and in the exchange of questions and answers which you are now involved in. You are to be commended for the conscientious manner in which you are weighing the importance of the facts in this issue.

We have enclosed some statistical charts relative to the FEHBP for the record and your information.

Attachment I shows both the Blue Cross and Blue Shield, as well as the FEHBP contract enrollment by employee status for the period 1970-1980.

At December 31, 1980, the annuitant contracts represented 33.7 percent of the FEHBP population.

At December 31, 1980, Blue Cross and Blue Shield annuitant contracts represented 60.4 percent of total annuitants.

Blue Cross
Blue Shield
Federal Employee Program

Congressman Ted Stevens
United States Senate

June 16, 1981
Page Two

As you can see, the percentage of active contracts for the entire FEHBP has steadily decreased while annuitant contracts have steadily increased. We expect this trend will continue.

Attachment II segregates Blue Cross and Blue Shield contracts by status, actives/annuitants, age and sex.

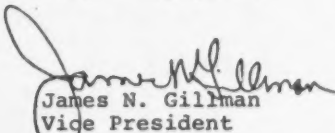
Attachment III, "Active Contract Growth 1976-1980" compares the increases/decreases in active contracts by carrier category and selected carriers within the FEHBP.

Please note that for the comparable periods, 1976-1978 and 1978-1980, the Government-wide Plans' active contracts have decreased by 8.4 percent and 10.2 percent respectively, while all other carriers' actives have increased.

Attachment IV, "Annuitant Contract Growth 1976-1980" shows that all carriers experienced increases in annuitant contracts for the comparable periods 1976-1978 and 1978-1980.

If we can be of any further assistance, either in providing you with additional information or working with you to thoroughly analyze this issue, please be assured that we are available.

Very truly yours,


James N. Gillman
Vice President

JNG/swj

Attachments

1. What percentage of federal employees and retirees participate in your plans?

As of March 31, 1981, the Blue Cross and Blue Shield Government-wide Service Benefit Plan (GWSBP) had 1,822,077 enrollees or approximately 49.7% of all federal employees and retirees enrolled in the Federal Employees Health Benefit Program (FEHBP).

2. In which of the options are retirees most concentrated?

Following are the number of retirees enrolled in the GWSBP as of March 31, 1981 by option and type of enrollment:

<u>High Option</u>			<u>Low Option</u>		
<u>Self Only</u>	<u>Family</u>	<u>Total</u>	<u>Self Only</u>	<u>Family</u>	<u>Total</u>
265,967	334,199	600,166	73,067	77,344	150,411

The High Option total of 600,166 represents 39.8% of all High Option contracts; the 150,411 Low Option total is 47.9% of all Low Option contracts. This combined total of 750,577 is 41.2% of the GWSBP enrollment and is approximately 60% of all federal government annuitants enrolled in the 120 carriers in the FEHBP. Of the annuitants enrolled with us, only 52.17% are 65 years or older. According to a recent study of claims filed with the GWSBP by subscribers 65 and over, it appears that 52.9% of the 65 and over annuitants have Medicare, A and/or B in addition to FEHBP coverage.

Some FEHBP plans are closed to annuitants; therefore, when retirement approaches, many federal employees change to Blue Cross and Blue Shield coverage or another carrier which is open to annuitants thus creating an imbalance among FEHBP carriers relative to the age mix and the resultant costs and utilization. This imbalance is reflected in the premium charged by the carriers.

3. What will be the impact on your premium structure if the Finance Committee proposal is adopted?

Based upon the best data available at this time, we project that the proposal would result in the following rate increases:

High Option Self +25%	Low Option +92%
High Option Self and Family +11%	Low Option Self and Family +37%

The above rate increase would be in addition to a rate increase in the range of 15-19% to accommodate the increased cost and utilization trends which the program is currently experiencing.

As mentioned in the previous answer, the fact that some FEHBP plan carriers are permitted to exclude annuitants results in Blue Cross and Blue Shield, and one or two other carriers, having the majority of annuitants. As a result of this proposal, a disproportionate financial burden is placed on the enrollees, active and retired, who are in these open plans. Therefore, the premium structures of the closed plans will be only minimally, if at all, affected. This may well make those plans more appealing because of lower premiums, and cause active federal employees (active only, since annuitants can't enroll) to change to those carriers from the ones who will have the significant rate increases resulting from this proposal. This will then result in an increased percentage of annuitants in the carriers affected by the proposal and cause increases in cost and utilization because of the annuitants use of health care. This will bring about a premium increase and the cycle will start all over.

4. Would retirees find it less expensive to opt out of the federal plans, be primarily covered under Medicare and take out supplemental coverage under a private sector plan than if they remained in the system, assuming the adoption of the proposed changes?

The current government contribution would reduce the cost in the GWSBP Low Option to where it would be more advantageous than supplemental coverage, especially since the Low Option has benefits not available under Medicare.

In determining the exact definition of "less expensive", we may be misled by examining only premium rates; we must also look at available benefits. If the supplemental coverage does not provide benefits for drugs, vision care, dental, etc., then even though the combined premiums of Medicare B and the supplemental coverage may be less than Medicare and FEHBP plan premiums, the out-of-pocket expenses which the retiree must pay when added to the lesser premium may well make the Medicare/supplemental coverage more expensive to the retiree.

It is difficult to predict which of the available courses of action will be chosen by federal retirees, however, our best evaluation of benefits and premiums leads us to believe that retirees with Medicare will leave the FEHBP plan and purchase a private supplemental coverage. It should be noted that those federal retirees who are not eligible for Medicare A would not be able to exercise the option described. These retirees, on a somewhat fixed income, would then have no choice but to shoulder the burden of the significant rate increases resulting from this proposal thus further eroding their income in an inflationary economy.

5. How does the Finance Committee proposal affect your current negotiations with OPM?

On March 30, 1981, the Office of Personnel Management wrote us requesting benefit and premium proposals for 1982 and stating that the benefit negotiations were to be completed by June 30, 1981. Because of the uncertainty caused by the proposal, negotiations have not proceeded to a point where it appears possible to meet the proposed deadline.

In general, OPM and carriers would not be willing or able to conclude negotiations until the Medicare primary/secondary issue is resolved so that benefit changes, if necessary, could be made. Since the proposal has a significant effect on rates, as shown in #3, carriers and OPM most certainly are not able to determine 1982 premium rates.

Also, we are unable to produce the printed materials necessary for Open Season and the 1982 benefit year until this issue is resolved. The discussions are somewhat stalled on the brochures, benefit information charts, etc.

6. Do you foresee the possibility where you may withdraw your health plans or drastically change the coverage as a result of the effect of the Finance Committee's proposal?

We do not intend to withdraw the Blue Cross and Blue Shield GWSBP.

While we do not intend to withdraw, we may be priced out of the FEHBP. We are concerned that as a result of

the Finance Committee proposal, the increase in our premium rates and the resultant movement of federal employees among the many carriers could bring about a situation where the GWSBP becomes too costly for many federal employees who want the security of the comprehensive benefits that the Blue Cross and Blue Shield Plan offers. Thus, our plan may become a haven, and an expensive one at that, for persons who are heavy utilizers of health care services. In a short time, even these persons would find it too costly and thus change to other carriers. We could then be faced with a serious question of our ability to remain a viable carrier.

Our current benefits will be modified to the extent that we will remove the provision which waives the Supplemental deductible (\$150 High Option and \$200 Low Option) and coinsurance (20% High Option and 25% Low Option) for persons with Part B of Medicare. If we did not make this change, there would be even greater rate increases than as stated in #3. We believe this change will result in the federal retirees with Medicare paying more out of their own pockets for health care at a time when they are assailed by the continuing erosion of the purchasing power of their fixed incomes.

7. Where will the Administrative burdens fall, assuming the adoption of this proposal?

We do not know how the Medicare program intends to administer its benefits as secondary payor. Does it intend to apply its full deductibles and coinsurances or might these be waived if the same services and supplies were subjected to deductible and coinsurance by the FEHBP carrier? Do Medicare benefits pick up after the FEHBP benefits are exhausted or do they run concurrently? Will Medicare always accept the FEHBP carriers' decision regarding medical necessity or level of care?

Even without knowledge of the Medicare program's answers to the above and many other essential questions, it is our opinion that almost all administrative burdens resulting from the Finance Committee proposal will fall on Medicare. Relatively few administrative burdens will be placed on FEHBP carriers. The Medicare program will have to determine which of the eligible beneficiaries claiming Medicare benefits are retired federal employees, which of these retired federal employees have FEHBP coverage, which of the 120 FEHBP plans the retired

federal employee is enrolled in, what are the benefits of that particular FEHBP plan involved and, did that FEHBP plan pay its benefits correctly. On the surface, it may appear that these are not difficult determinations to make. It may be that the existing Medicare claim forms and administrative processes allow for these determinations. Nonetheless, we feel compelled to call your attention to the numerous points of determination as mentioned above in comparison to the singular point of determination the Medicare program currently addresses, i.e., is this claimant an eligible Medicare beneficiary.

Each of these new points is an area where error can and will occur because of faulty information or documentation from beneficiaries, providers, other carriers, government agencies, and the Medicare program itself. Each of these points will add to processing time. When error does occur, the providers and subscribers will contact the Medicare service areas in intermediaries and carriers for information and assistance. Surely, this will burden to some extent the existing administrative capacities and costs of the Medicare program.

We believe the claims processing and service functions of the Medicare program's intermediary and carriers will be complicated considerably for the adjudication of claims for federal retirees. This may be a relatively small percentage of the total volume of Medicare claims but it is acknowledged that in the health insurance industry as in many industries, a large percentage of administrative costs is related to those items which do not fall within the ordinary procedures of routine processing. These often require special handling which can be costly. Automated systems may not be designed or modified for a small volume of activity. All of which portends increased administrative activity by the Medicare program which will result in added administrative burden and increased costs, coupled with the added complexity in administration which will be perceived and experienced by beneficiaries and providers to the detriment of the Medicare program.

ATTACHMENT I

Blue Cross and Blue Shield
Federal Employee Program

ITP CONTRACT ENROLLMENT BY EMPLOYEE STATUS, 1970 - 1980

	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979	1980
Active Percent	1,350,000 83.1	1,361,742 81.4	1,300,389 78.2	1,348,364 75.9	1,412,076 74.5	1,457,504 73.5	1,369,091 70.8	1,289,096 69.3	1,234,509 65.2	1,191,123 61.4	1,107,210 60.1
Annuity Percent	274,462 16.9	310,581 18.6	362,390 21.8	427,567 24.1	482,527 25.5	526,078 26.5	563,791 29.2	597,904 31.7	631,059 33.8	688,580 36.6	734,076 39.9
TOTAL Percent	1,625,282 100.0	1,672,323 100.0	1,662,779 100.0	1,775,931 100.0	1,894,603 100.0	1,983,582 100.0	1,932,882 100.0	1,887,000 100.0	1,865,568 100.0	1,879,703 100.0	1,841,286 100.0

FENBP CONTRACT ENROLLMENT BY EMPLOYEE STATUS, 1970 - 1980

	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979	1980
Active Percent	2,200,215 83.2	2,173,705 80.9	2,224,085 79.4	2,198,573 76.7	2,235,890 74.4	2,288,887 72.7	2,305,431 71.5	2,312,088 70.1	2,347,436 69.2	2,353,500 67.4	2,263,859 66.3
Annuity Percent	442,835 16.8	515,440 19.2	575,539 20.6	669,010 23.3	769,096 25.6	857,857 27.3	920,072 28.5	985,444 29.9	1,045,589 30.8	1,137,591 32.6	1,214,524 33.7
TOTAL Percent	2,643,050 100.0	2,689,145 100.0	2,799,624 100.0	2,867,583 100.0	3,004,986 100.0	3,146,744 100.0	3,225,500 100.0	3,297,532 100.0	3,393,025 100.0	3,491,091 100.0	3,598,383 100.0

BC/BS Actives As Percent
of Total Actives

61.4

62.7

58.5

61.3

63.2

63.7

59.4

55.8

60.7

60.4

60.5

45.5

BC/BS Annuity As Percent
of Total Annuity

62.0

60.3

63.0

63.9

62.7

61.3

61.3

60.7

60.4

60.5

60.4

ATTACHMENT II

BLUE CROSS AND BLUE SHIELD ASSOCIATIONS
GOVERNMENT-WIDE SERVICE BENEFIT PLAN

TABLE OF CONTRACT EFFICIENCY BY AGE AND SEX

Actives					Annuityants				
AGE	SEX				AGE	SEX			
* FREQUENCY	PERCENT	ROW PCT	COL PCT	TOTAL	* FREQUENCY	PERCENT	ROW PCT	COL PCT	TOTAL
	Male	Female				Male	Female		
1	300	323		4039	1	1307	1207		2514
0-19	0.07	0.29		0.37	0-19	0.18	0.15		0.34
	13.81	80.14				51.99	49.01		
	0.11	0.85				0.33	0.41		
2	27307	35012		56317	2	538	591		1131
20-24	1.44	3.25		5.11	20-24	0.27	0.25		0.15
	35.05	53.94				47.57	52.43		
	2.79	9.57				0.12	0.27		
3	74202	60211		134413	3	464	537		1023
25-29	5.73	5.45		12.13	25-29	0.25	0.07		0.14
	55.23	44.87				45.25	53.74		
	17.21	16.07				0.11	0.13		
4	115771	52247		176943	4	1934	1267		2901
30-34	17.58	5.45		16.04	30-34	0.21	0.17		0.38
	65.95	34.35				54.77	45.23		
	15.05	16.01				0.35	0.43		
5	91999	43071		134970	5	2574	1977		4566
35-39	8.33	3.97		12.24	35-39	0.35	0.27		0.62
	58.09	31.91				56.81	43.19		
	12.54	11.45				0.59	0.67		
6	82972	34655		117647	6	4207	3431		7645
40-44	7.52	3.14		10.66	40-44	0.57	0.47		1.04
	70.54	29.45				55.03	44.97		
	11.52	9.21				0.75	1.17		
7	95562	33847		130509	7	9202	6587		15799
45-49	8.75	3.07		11.83	45-49	1.25	0.92		2.15
	74.27	25.93				58.28	41.72		
	13.32	8.97				2.08	2.25		
8	133748	37503		141551	8	22395	15455		37852
50-54	9.43	3.43		12.83	50-54	3.05	2.11		5.16
	73.29	26.71				59.17	40.83		
	14.27	10.02				5.07	5.23		
9	83033	38945		121978	9	81453	35622		117273
55-59	7.53	3.53		11.06	55-59	11.79	4.85		15.95
	58.07	31.93				49.57	30.43		
	11.42	10.35				18.45	12.17		
10	41477	20302		61769	10	117019	50755		160775
60-64	3.75	1.84		5.59	60-64	14.98	8.91		21.90
	57.17	32.93				54.43	31.57		
	5.72	5.47				24.92	17.35		
11	15071	7972		23343	11	227725	175364		343370
≥ 65	1.37	0.77		2.09	≥ 65	28.29	23.34		52.17
	65.13	34.67				54.22	45.78		
	2.37	2.12				47.05	52.95		
TOTAL	725822	376297		1103119	TOTAL	441623	297297		734219
	65.99	34.11		100.00		39.12	39.83		100.00

* Frequency = Number of contracts

Percent = Percent of total actives/annuityants

Row Percent = Percent of actives/annuityants in age category - male/female

Column Percent = Percent of all actives/annuityants - male and female

Active Contract Growth 1976-1980
By Carrier Category and Selected Carrier

	1976	1978	Percent Change	1980	Percent Change
GOVERNMENT-WIDE PLANS					
Blue Cross-Blue Shield	1,649,249	1,510,694	(8.4)	1,356,681	(10.2)
Aetna	1,381,195	1,243,285	(10.0)	1,121,885	(9.8)
	268,054	267,409	(0.3)	234,796	(12.2)
ALL EMPLOYEE ORGANIZATION PLANS	433,058	581,083	34.2	743,286	27.9
*Selected Employee Organization Plans					
American Postal Workers Union	143,027	149,096	4.2	156,682	5.1
National Association of Letter Carriers	117,117	122,730	4.8	125,871	2.6
Government Employees Hospital Association	27,971	56,077	100.5	85,524	52.5
Rural Carrier Benefit Plan	21,833	22,961	5.2	23,178	1.0
ALL COMPREHENSIVE MEDICAL PLANS	223,121	255,659	14.6	283,891	11.0
**Selected Comprehensive Medical Plans					
Kaiser of Northern California	43,668	48,570	11.2	50,781	4.6
Kaiser of Southern California	33,927	38,171	12.5	41,141	7.8
TOTAL	2,305,428	2,347,436	1.8	2,383,858	1.6
Postmasters	11,769	18,625	58.3	59,345	218.6
Alliance	24,884	98,177	294.5	101,397	3.3
Mailhandlers	34,637	56,077	61.9	107,500	91.7

* Included in total of all Employee Organization Plans

** Included in total of all Comprehensive Medical Plans

ATTACHMENT IV

Annuitant Contract Growth 1976-1980
By Carrier Category and Selected Carrier

	<u>1976</u>	<u>1978</u>	<u>Percent Change</u>	<u>1980</u>	<u>Percent Change</u>
GOVERNMENT-WIDE PLANS					
Blue Cross-Blue Shield	745,893	831,417	11.5	954,909	14.8
Aetna	545,098	612,691	12.4	715,419	16.8
	200,795	218,726	8.9	239,490	9.5
ALL EMPLOYEE ORGANIZATION PLANS	122,924	152,451	24.0	184,882	21.3
•Selected Employee Organization Plans					
American Postal Workers Union	39,384	47,583	20.9	57,359	20.5
National Association of Letter Carriers	40,541	48,928	20.7	55,002	12.4
Government Employees Hospital Association	7,349	10,568	43.8	13,190	24.8
Rural Carrier Benefit Plan	11,110	13,718	23.5	16,786	22.4
ALL COMPREHENSIVE MEDICAL PLANS	51,255	61,721	20.4	74,733	21.1
••Selected Comprehensive Medical Plans					
Kaiser of Northern California	15,430	18,016	16.8	20,892	16.0
Kaiser of Southern California	8,438	10,084	19.2	12,095	19.9
TOTAL	920,072	1,045,589	13.6	1,214,524	16.2

• Included in total of all Employee Organization Plans

•• Included in total of all Comprehensive Medical Plans



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NATIONAL ASSOCIATION OF RETIRED FEDERAL EMPLOYEES
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June 16, 1981

The Honorable Ted Stevens
Chairman, Subcommittee on Civil Service,
Post Office and General Services
U. S. Senate
Washington, D. C. 20510

Dear Senator Stevens:

Please find enclosed this Association's response to the questions directed to us as part of the record of the June 2 Hearing on The Impact of Current Proposals on Federal Employees Health Benefits Plans.

We appreciate this opportunity to address specific questions and hope these answers will be helpful to you.

Sincerely,

Michael C. Nave
Michael C. Nave
President

Enclosure

QUESTIONS TO THE NATIONAL ASSOCIATION OF RETIRED
FEDERAL EMPLOYEES FOR THE FEDERAL
HEALTH BENEFIT PLAN HEARING RECORD

1. What percentage of Federal retirees are covered by Medicare?

We have no way of knowing exactly. About 62 percent of all current retirees and survivors are age 65 and older and would thus meet the age requirement for Medicare coverage, but obviously all of these annuitants do not have full (Parts A and B) Medicare coverage. We believe an optimistic estimate would be about 50 to 55 percent of Federal retirees over age 65. Of course anyone, Federal or non-Federal, over age 65 is eligible for Medicare Part B if they elect it and pay the monthly premium, currently \$9.60 per month. We would estimate that most Federal retirees over age 65 have Medicare Part B.

2. What health plans do retirees tend to participate in the most? What are the average premiums for such plans?

Approximately 955,000 annuitants, or 60 percent, are enrolled in one of the two Government-wide plans, Blue Cross/Blue Shield or Aetna. 715,419 annuitants are enrolled in Blue Cross/Blue Shield; 239,490 are enrolled in Aetna. OPM statistics indicate that the majority of all enrollees carry family coverage and, of course, for the elderly retiree this usually means only the retiree and spouse. The majority of retirees currently have high option family coverage. While it is true and well publicized that Federal retirees with full Medicare coverage (Parts A and B) can obtain adequate supplemental coverage through a low option plan, it must be remembered that in order to have a family, or spouse, adequately covered, all family members must be entitled to full Medicare coverage before low option becomes a viable alternative.

Many retirees who are themselves fully covered under Medicare have not yet switched to low option because the spouse is not yet eligible for Medicare.

The Blue Cross/Blue Shield high option/family coverage is \$66.13 per month. Aetna high option/family is \$32.74 per month. Blue Cross/Blue Shield low option/family is \$15.47 per month. Aetna low option/family is \$16.38 per month.

3. Can a Federal retiree drop his or her Federal plan and take out private insurance? If he or she did that, would Medicare be the primary or secondary payer?

Yes, in most cases a Federal retiree could drop his, or her, Federal plan and take out private insurance to replace it, but adequate coverage for the individual without full Medicare coverage would be prohibitive in cost due primarily to the age of the individual. We have been informed that in some areas, insurance companies will not sell policies to persons who are eligible for FEHB coverage but we do not know how widespread this practice is. However, were an individual to drop the Federal plan and take out private insurance, Medicare would be the primary carrier, as even under the proposed change Medicare would remain primary carrier in coordination with all insurance except FEHB plans.

4. What prices must the retiree pay to get similar supplemental coverage from the private sector?

The cost would differ slightly from area to area, but in neighboring Maryland the Blue Cross/Blue Shield preferred supplemental Medicare policy (supplementing Medicare A and B) is \$400 per year, per person and that policy provides for only partial drug and medicine coverage. For the individual who would be able to use this preferred Medicare supplemental policy, the current annual premium under the FEHB BC/BS low option/self only would be \$63.96.

5. Would your organization support separate plans for the retired Federal workers?

We do not believe a separate plan for retired Federal workers would be beneficial for either the retirees or the Government as former employer. From 1961 until the present, there have been a certain group of retirees and survivors, i.e., those who retired before July 1, 1960 under a program known as the Retired Federal Employees Health Program, and the vast majority of these ~~FEHB~~ FEHB, have been fully covered by Medicare. However, experience has shown that this program, covering only older retirees, is not cost efficient and OPM is currently proposing to automatically shift all RFEHB enrollees into a low option FEHB plan which under the current set-up would benefit both the retirees and the Government. While this shift was originally intended to take place July 1, 1981, OPM recently advised that they were postponing the shift until the effects of the current Finance Committee proposal could be taken into account for impact on both retiree and Government cost.

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